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JANUARY 1956

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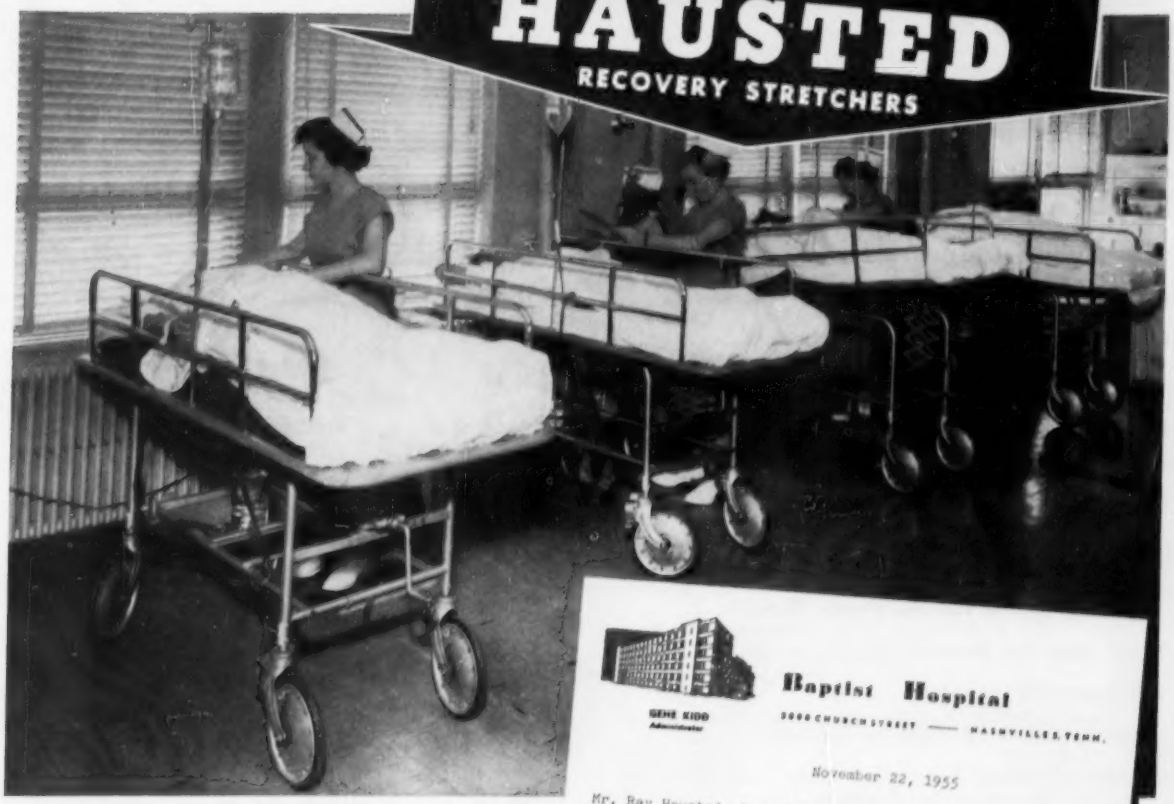

GENE KIDD
Administrator

Baptist Hospital

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November 22, 1955

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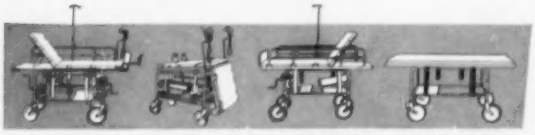

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The Modern Hospital

JANUARY 1956

VOLUME 86, NO. 1

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AMONG THE AUTHORS


Edward H. Heyd

Edward H. Heyd, author of the article on page 77, has been administrator of Children's Hospital, Cincinnati, since 1949. After receiving his A.B. degree in business administration and a master's degree in psychology from Rutgers University, Mr. Heyd did not go immediately into hospital work but was first an assistant dean of men, a sales manager of the country's second largest fuel company, general manager of a bakery, and a member of the industrial relations staff of the DuPont Company. In 1939, he went to Memorial Hospital, Wilmington, Del., where he stayed as superintendent until 1942. During the war, Mr. Heyd entered the army as a second lieutenant and was discharged a lieutenant colonel after graduating from the Command and General Staff School at Fort Leavenworth, Kan. Active in Ohio hospital associations, Mr. Heyd is a past president of the Cincinnati Hospital Council, a member of the Ohio Hospital Association board of directors, as well as being on the board and executive committee of the Greater Cincinnati Safety Council and a member of the board of the Society for the Advancement of Management.


Samuel Horwitz

Samuel Horwitz, whose article on nursing problems appears on page 59, is a practicing lawyer in Cleveland—a graduate of Western Reserve University Law School. In 1951, he became a trustee of Mount Sinai Hospital, and chairman of its committee on nursing and ancillary services. As he became more absorbed with the problems of the nursing shortage, he accepted membership on the commission sponsored by the Cleveland Hospital Council and League of Nursing. The commission made a survey of the nursing problems of that area, and it is from that survey that his statement stems.


Eleanor Gee

Eleanor Gee, whose article on planned diet instruction for patients appears on page 112, is director of nutrition at Maine General Hospital, Portland, Maine. A graduate of Nasson College, Springvale, Maine, Mrs. Gee interned at Methodist Hospital, Philadelphia. Before joining the Maine General staff in 1940 as an assistant dietitian, she was an assistant dietitian at Newton-Wellesley Hospital, Newton, Mass., and Methodist Hospital, Philadelphia. Mrs. Gee has been Maine General's director of nutrition since 1944.

Also in this issue, **Isadore** and **Zachary Rosenfield,** architects and hospital consultants of New York City, familiar to The MODERN HOSPITAL readers as authorities on hospital planning and construction, describe this month's "Modern Hospital of the Month," Belleville Hospital, Belleville, Ill. **Ruth Perkins Kuehn,** dean of the school of nursing, University of Pittsburgh, presents the final article in the series of operating room studies conducted by **Edna Prickett,** operating room consultant with the National League of Nursing, and **Carl Linderoth,** a former member of the Methods Engineering Council of Pittsburgh. **Dr. John W. Cronin,** chief of the Division of Hospital and Medical Facilities, Public Health Service, Washington, D.C., and **Dr. Louis Block,** chief of the division's Research Grants Branch, explain the hospital research grants program on page 72.

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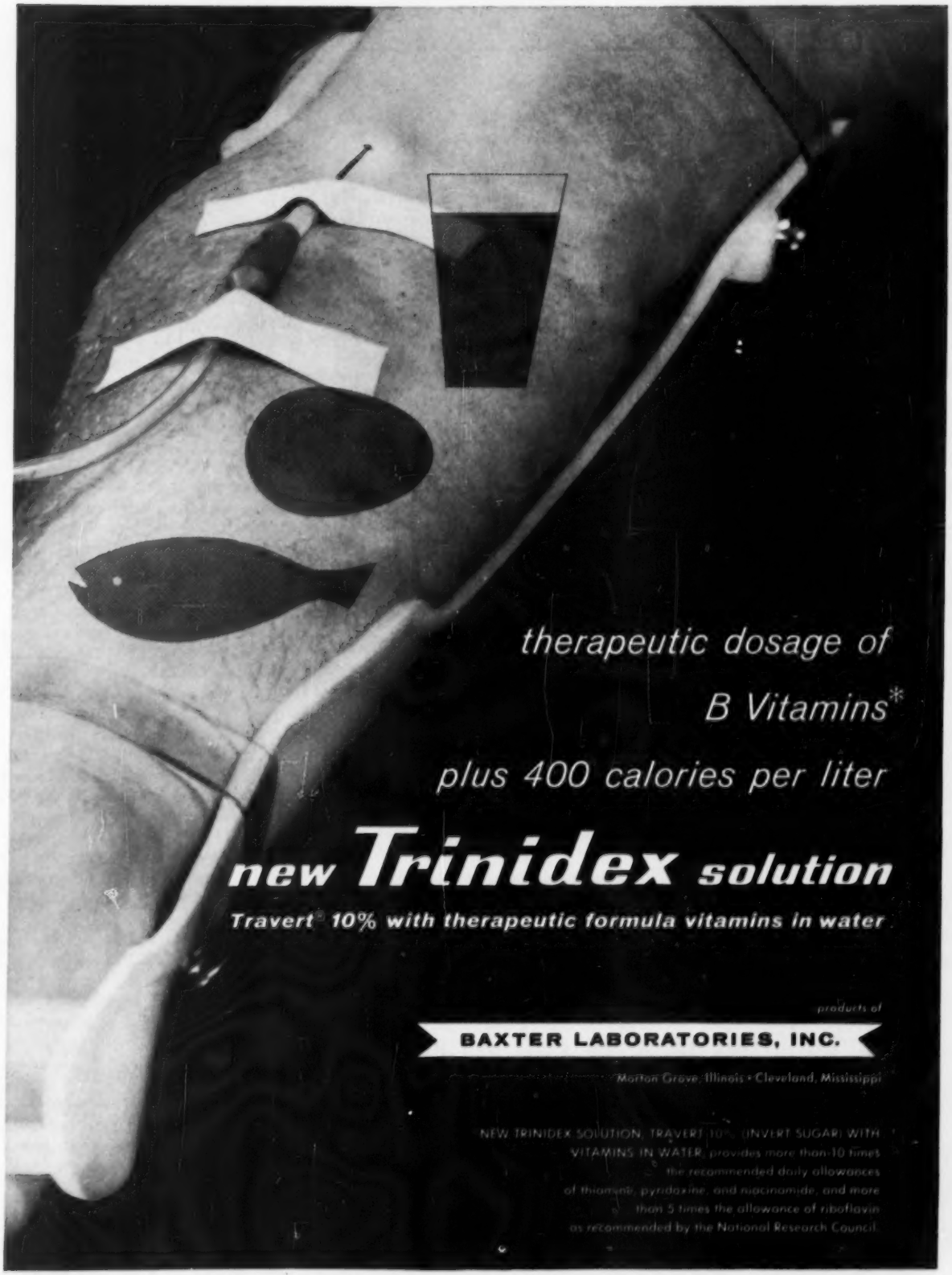

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READER OPINION

Economics of Hospital Food Service: Pro and Con

Sirs:

The special report submitted by Ernest N. May, president of the Charitable Research Foundation, Inc., "to give clear, practical, reliable information to enable their management to function intelligently and efficiently," in the October issue of The MODERN HOSPITAL is thought-provoking and worthy of careful reading.

One cannot discount the author's emphasis placed on *design* and *operation* as a strong contributing factor to efficient food service, or his statement that "nothing is sadder in this entire business but nothing is more common than to spend a fortune on bricks and mortar and stainless steel, then to refuse to provide the *trained* man-hours necessary to preserve that expenditure and let it perform its task."

It is agreed that the areas which Mr. May has designed in his study are the "bricks and mortar and stainless steel" of the dietary department. Mr. May has failed, however, to consider the important factor, *service*, which cannot be measured by the slide rule, nor has he considered the food standards. Mr. May's algebraic equation seems to be: Ideal physical setup manned with the correct number of employes equals the ideal food service.

To evaluate a dietary department following the pattern in this study, labor requirements, general facilities, raw food costs, quality and palatability of the food are the common yardsticks by which the dietary service is measured. Added to this is the very interesting and detailed report on thermal efficiency which is worthy of study. The value here is that this study places emphasis on the correct temperature of foods, an ever present criticism of food, and a most important one.

In this report, *little emphasis* is given to the very foundation of good food and its service: the standard of food, the preparation, the taste of food, the timing of preparation as it relates to service. Quoting Mr. May, "Time is the heart of the whole matter, elapsed time," but I feel our author has omitted an important phase by checking only the elapsed time in transit. Elapsed time should include the preparation and/or cooking as well as the service. "Hot food hot and cold food cold" is a long used motto for food service, but if these requirements are met and the basic product is poor, the *food service* is not satisfactory.

Although the author states that "geographical location has nothing to do with the problem, distance has nothing to do with the problem, the size of the hospital has nothing to do with the problem," these factors do have to be met and *are* a contributing factor to *elapsed* time.

The importance of elapsed time and methods of distribution and service are areas where many food service departments should take time to study their present-day operations, and I believe this is probably the keynote of this entire report.

Mr. May has made some rather broad statements which may be based upon the present emphasis placed on hospital costs, and since the dietary department costs are sizable, at least

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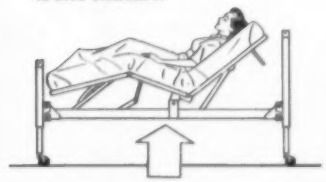

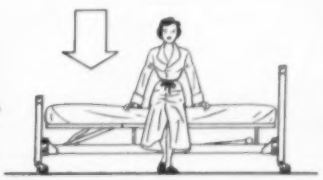

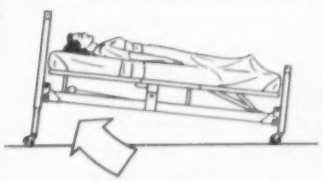

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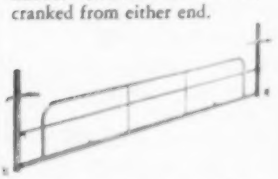

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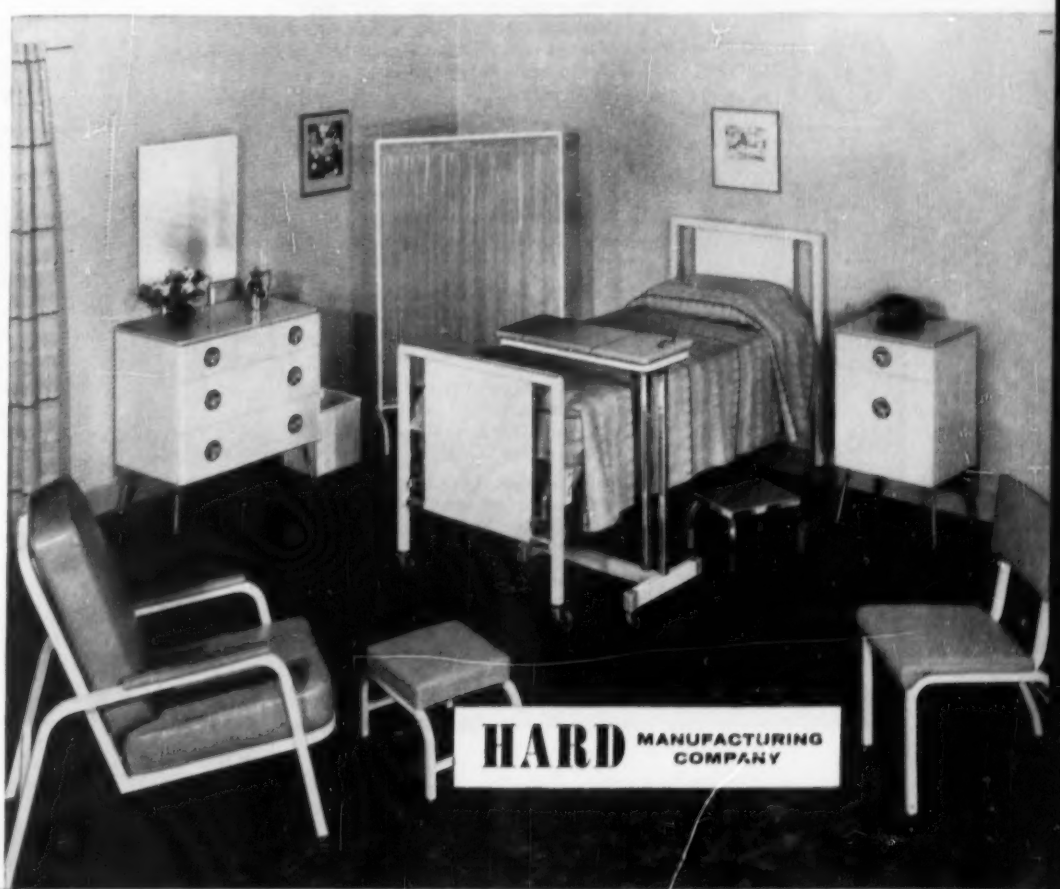

20 per cent of the hospital operating budget, this account is one which can be "tapped." Mr. May states, "Usually this account can show considerable savings without affecting patient care." Here again I disagree with the author. Upon analysis of the per diem cost of the patient, the dietary service shows a very small per cent of the total patient costs, yet it is the one service by which the hospital is judged, and a poor or good public relations medium, whatever the case may be. Everyone is a "specialist" in food, and the tray is, and should be, the highlight of the patient's day. Limited budgets *do* affect the service.

In summarizing the studies of the 15 hospitals, Mr. May can find no common denominator for operations in the various hospitals—whether in area, labor, food costs, management, quality or palatability.

The author apparently discounted as absolutely useless any published material on the subject of hospital dietary departments. He states, "It is readily seen that personal opinions concerning the performance of any type of service are absolutely of no significance unless they are based on data resulting from experience observation, buttressed always by a careful examination of the records of that service, *plus* a positive knowledge of others' comparative performance."

Mr. May is very uncomplimentary to the abundance of material which has been published, "published presumably in an attempt to assist the uninitiated in the making of hundreds of decisions necessary to achieve an efficient result. Unfortunately, many of these literary efforts, including many by qualified professional persons, are practically useless. They are merely an indiscriminate mixture of whims, conjectures and prejudices, from which it is next to impossible to distill any small quantity of factual material which may be present. Those persons in need of assistance are therefore unable to winnow the meager wheat from the chaff of current literature. . . . From all appearances, even most of the presumed 'initiated' have an inadequate knowledge of their own subject."

I can't quite agree with Mr. May that all reference material on the operation and design of dietary departments is poor and based only on one opinion, nor do I agree with the recommendations and conclusions made as a result of this study. Certainly the study has given to the readers excellent source material for a type of dietary service, perhaps an ideally functioning organization, design and operation-wise, but you should add to this the often forgotten factor, the taste of the food, its eye appeal and service for a complete evaluation.

In conclusion Mr. May states there are three final but basic conclusions, perhaps the most valuable in the whole survey:

1. "No one factor contributes so much to the efficient and economical operation of a dietary department as the presence and competence of a sufficient amount of good *management*.

2. "Second only to management in importance is the necessity for intelligent planning in the design of the department.

3. "The potentially best type of tray service is a centralized system. With good management and proper design, centralized service can and should be as good a job as any other type, and requires less investment, less labor, less supervision and less foods."

This third conclusion is a controversial one, and I feel that such a

conclusion should be evaluated as one based on a study of 15 hospitals and possibly some personal opinion.

The recommendations on areas, food stores, refrigerators, cafeteria counter and dining rooms, formula room (many dietary departments operate these, although the author states otherwise), tray service, tray truck, storage and washing, equipment, patient tray service, garbage disposal, staff requirements (Mr. May here has a simple formula for dietitian requirements), total man-hours, return of investment, type of service, quality point rating of foods for nutritional adequacy, quality of foods purchased, and food preparation and thermal efficiency are worthy of study. The basic factors are sound and certainly are good source material. However, in the entire study I feel that one of the most important phases of the dietary food service has been relegated to one of little importance, *i.e.* the "eaten food," or let's say the "uneaten food," and the special service to the patients—that which contributes so much to their welfare. Certainly this cannot be accomplished by a "mechanized" organization, evaluating raw food costs by minimum costs, rather than *quality foods.*

As I read the article by Mr. May, his attitude toward the hospital field as a whole certainly lent itself to a feeling that one may have little respect for the *management* of hospitals.

The entire management receives its share of criticism, and the reasons given are: "lack of incentive to do better, lack of leadership, lack of the standardized accounting systems necessary for true comparisons, lack of education in and emphasis on the relationship between cost and performance, fear of being considered heretical and fear of conflict"—and so to the dietary department — where "indifference, carelessness and lack of knowledge are annually costing hospitals tens of millions of dollars in this one unappreciated back-door department — dietary . . . a department using 20 per cent of the total operating budget. . . . By saving 30 per cent of that item one also saves 8 per cent of the total cost."

The author failed to state how the 20 per cent cut affects quality food, high standards of preparation, trained personnel, and adequate supervision and service, which contribute as much to the welfare of the patient and the hospital service as do the previously mentioned factors listed in this study.

Service is hard to evaluate in dollars and cents. Efficiency in operation can be. Both contribute an equal share to a successful dietary service.

Elizabeth Perry
Assistant Superintendent
City Hospital
Cleveland

Sirs:

I have read the article "Economics of Food Service" with great interest. It points up the need for further study on the factors influencing the quality and cost of hospital dietary services. As Mr. May has pointed out, "Hospitals are in need of clear, practical, reliable information which will enable their management to function intelligently and efficiently." Objective standards are essential to measure progress. Dissemination of data such as Mr. May's from departments which are considered to be well planned and managed will stimulate self-evaluation and further study.

"Economics of Food Service" again brings into focus the need for an analysis of factors which promote labor economy. As pointed out, layout, organization and management all influence the value received from money spent. More realistic data on equipment output are essential before the return on investment can be accurately computed. A critical analysis of production costs is long overdue.

Collection of such information on production costs (labor hours) under different organizational structures and management is time consuming and complicated. So many factors are involved that it is hard to draw conclusions without weighting the effect of each variable. Recent advances in food technology alone have outmoded a large portion of our previous experiences. However, with a method of recording time according to detailed function it would be possible to measure the effect of each variable. Further reports from the Charitable Research Foundation are eagerly awaited.

The standards presented in the article for measuring the quality of dietary services are very interesting. Further refinement of this technic to include other areas of administrative competence would be a worthy project.

Ruth Dickie
Chief Dietitian
University Hospitals
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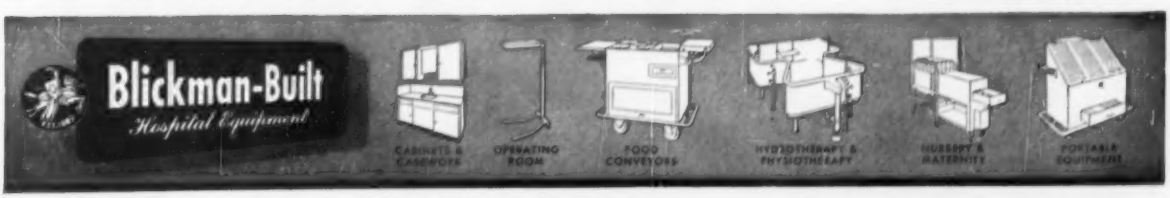

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The Iowa Case

Sirs:

Having been familiar with a number of previous state and federal court cases bearing on the "practice of medicine by hospitals and allied subjects," I felt it a foregone conclusion that the Iowa case would be lost if the hospital representatives claimed that radiology and pathology and anesthesiology are not the practice of medicine. The hospitals should have accepted these specialties as the practice of medicine. They should have made their case on the ground that because a physician is on salary, or other agreed compensation from a hospital, the physician does not thereby become an employe of the hospital nor is the hospital therefore "engaged in the practice of medicine."

The legal position of a salaried physician in a nonprofit agency is that of an "independent contractor," *i.e.* an expert who retains the full responsibility for his professional judgments and decisions. It is just because he is qualified to make and that he does make these independent professional decisions that the hospital engages him to pursue professional practice under its auspices. The hospital is not thereby practicing medicine. The physician is.

The distinction between nonprofit medical agencies on the one side and the proprietary hospitals and business corporations on the other has been adjudicated many times. The reason is not clear why Judge Moore brushes it aside. The basis of the legal distinction has been that whereas in the business corporation or proprietary hospital, there is a financial incentive on the part of the agency to influence the physician's professional decisions in directions which would yield profit to the organization and thus reduce the physician to the status of an employe, in the instance of the nonprofit agency, there is no such pecuniary incentive toward subordinating the physician's professional independence.

Present facts and recent trends in medical service and in the organization of hospitals are essential elements in the preparation of a valid case. A growing part of the practice of medicine is performed by physicians who are on salary from organizations. The physicians on full-time salary amounted to 35 per cent of all physicians in the U.S. in 1950 (excluding those retired), a percentage two and a half times greater than 20 years earlier. Improvements in hospital and clinic organization and in control of quality of service have spread from some large to many medium sized and some small institutions and have been accompanied by an increase in salaried physicians. The growth of certain types of voluntary health insurance plans has contributed to the same result. These trends have been considered legally relevant by high state and federal courts in this country.

Is it a joke or a tragedy that the question of so-called illegal "corporate practice" is not raised when the salaried physician is caring for *nonpaying* patients? Is the real issue thus economic rather than professional?

Many relevant court decisions do not seem to have been utilized by either side in the Iowa pleadings or in the judge's findings. I hope that the Iowa hospitals will take advantage of them in appealing to the Iowa State Supreme Court and in laying a legal basis at the same time for an appeal to the federal courts, should that be necessary.

Michael M. Davis

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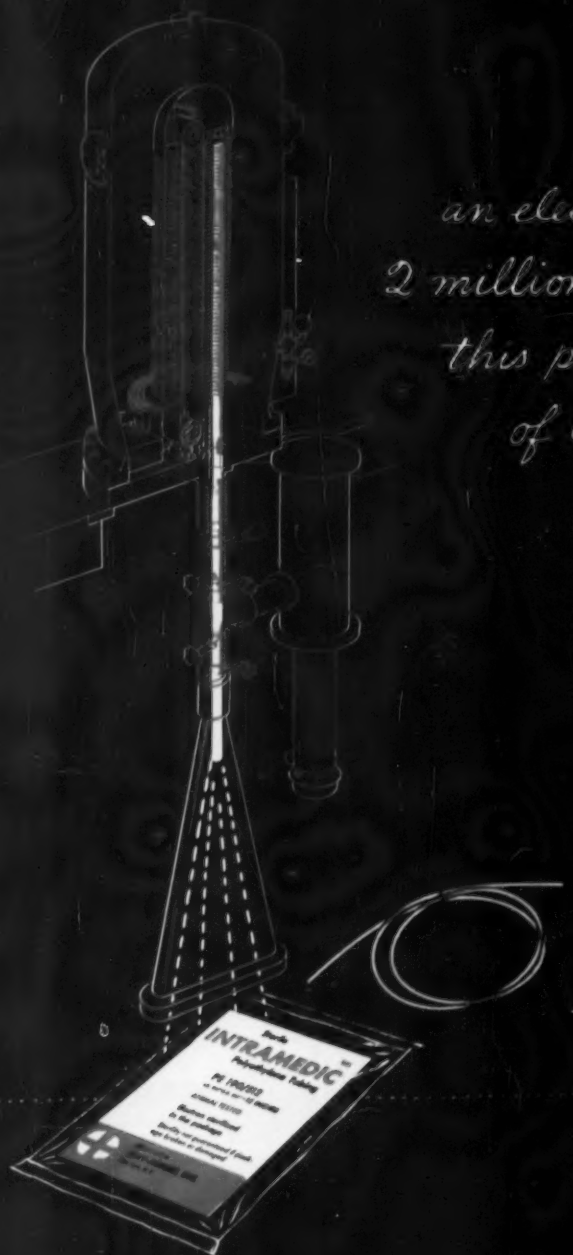

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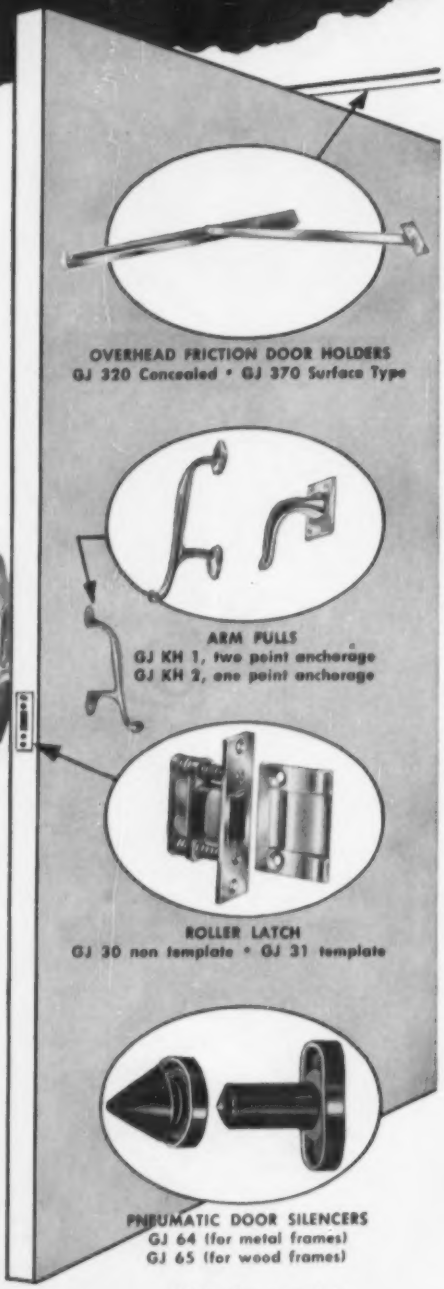

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"And here is where my room was," the mother said as she pointed to a window on the third floor.

"This is a beautiful certificate," observed her friend. "It certainly was thoughtful of the hospital to give this to you." The mother smiled and replied "This came from the administrator . . . see, here's his signature."

Words like these have been spoken many times by many mothers. No wonder mothers have come to expect a beautiful birth certificate when they leave the hospital. But after all, isn't having a baby something very important and very special?

And so it is. To the mother, birth is nothing short of a miracle, and she participated in it. Her baby is a miracle, too. From her point of view she feels that her baby deserves to have his entry into the world proclaimed from the house tops. She will forget the pain of birth but she will never forget the joy of it.

The Hollister® *Inscribal*® Birth Certificate you give her is associated with the joy of her miraculous experience in your hospital. When you present her with a beautiful Hollister Certificate, it becomes your hospital's warm recognition of this happy time for her. And to that small measure she feels you have understood her joy and acknowledged this momentous occasion of her life.

When you come right down to it, isn't this a wonderful way to have people say nice things about your hospital? Surely, this is a splendid way to build goodwill!

HOLLISTER

FRANKLIN C. HOLLISTER COMPANY
833 N. ORLEANS ST. • CHICAGO 10, ILLINOIS

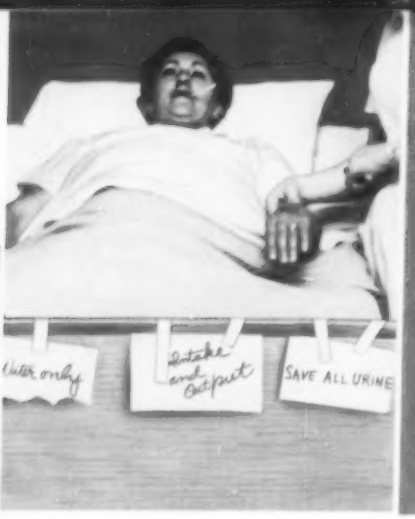
Please send to me, by return mail, your FREE Birth Certificate Portfolio, with actual samples.

NAME _____ TITLE _____

HOSPITAL _____

STREET ADDRESS _____

CITY _____ ZONE _____ STATE _____



Unsightly tape and paper notes look messy, mar hospital's appearance

Modern Hollister Bed Signs add neatness and beauty to hospital's appearance

Beautify your hospital *with* HOLLISTER BED SIGNS . . .

Now you can eliminate the unsightly eyesores of makeshift tape and paper reminder notes that clutter up patients' beds. The beautiful Hollister Bed Sign has an attractive, neat appearance that enhances any bed, whether new or old. And the simple, modern design fits in with any decor. Made of gleaming Plexiglas*, the Hollister Bed Sign is easy to keep hospital-clean.

In addition to its beauty, the Bed Sign helps make the nurse more efficient and better informed about her patients. It quickly and clearly reminds her of doctors' instructions. Now, nurses, aides and orderlies coming on duty can tell at a glance what they should know about their patients. The signs are slotted so that bright-colored reminder cards slip in and out in seconds. Instructions on the reminder cards are printed in large, easy-to-read type. The cards are fully enclosed and protected inside the slots . . . they won't bump or fall out, and resist tampering by children.

Hollister Bed Signs are designed to be permanently attached to the beds. Once on, they never need to be replaced. They can't be pilfered, mislaid or fall off. And they can be re-installed on new beds if old beds are replaced.

Find out how easy it is to beautify your hospital with the modern Hollister Bed Sign. Send in the coupon at left for the free Bed and Room Sign Brochure.

*Plexiglas is a trade mark of Rohm & Haas Company, Philadelphia, Reg. U. S. Pat. Office and other principal countries in the Western Hemisphere.

HOLLISTER

FRANKLIN C. HOLLISTER COMPANY
833 N. ORLEANS ST. • CHICAGO 10, ILLINOIS

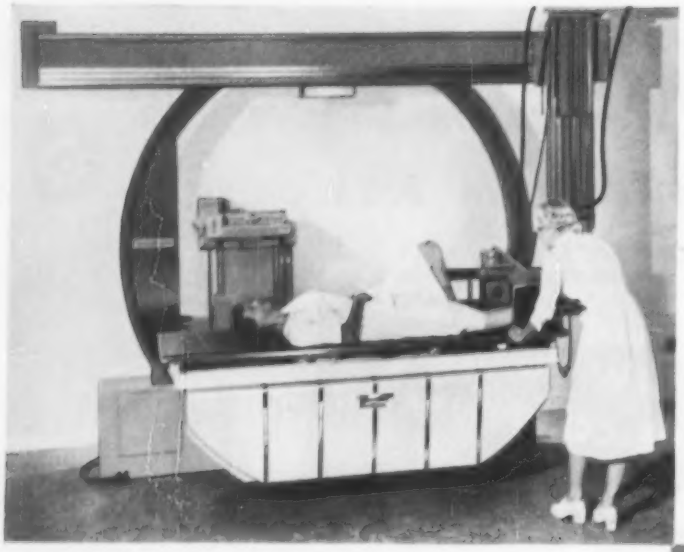
Please send to me, by return mail, the FREE illustrated Bed and Room Sign Brochure, with prices and quantity discounts.

NAME _____ TITLE _____

HOSPITAL _____

STREET ADDRESS _____

CITY _____ ZONE _____ STATE _____



A 500-MA IMPERIAL

FOR JUST $20.00 A DAY

Yes — for this "working day" sum, you can enjoy all the advantages of a deluxe Imperial 500-ma diagnostic x-ray unit, complete with spot-film device and phototiming.

A 200-MA MAXICON®

FOR JUST $7.50 A DAY

Truly professional facilities are afforded by this 200-ma, full-wave rectified, single-tube (over-under-table), hand-tilt diagnostic x-ray unit — yours for this small rental charge.

RENT
the x-ray apparatus you need through
G-E MAXISERVICE®

MANY factors affect the economics of x-ray equipment ownership. By actual cost analysis, you may find that General Electric's Maxiservice Rental Plan is exactly what you need.

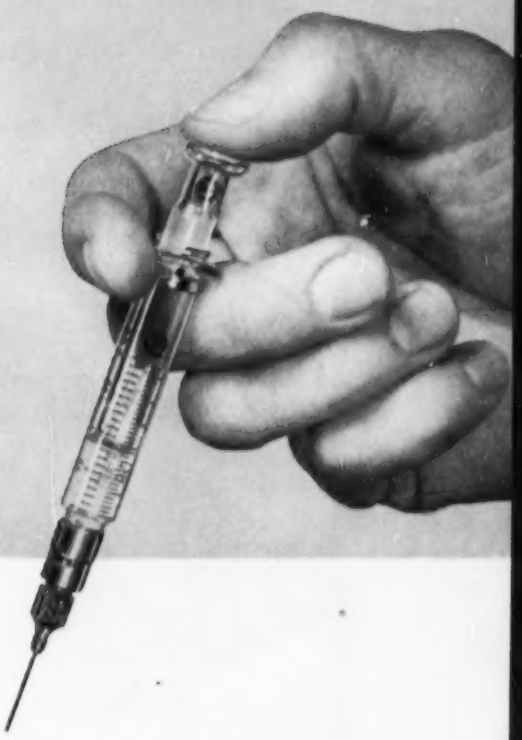
There's no initial capital investment. You get modern apparatus equipped for the latest technics. More than that, this apparatus *stays* up to date, thanks to periodic replacement option. A single, monthly rental charge includes repair parts, tubes, maintenance and local property taxes. Your rental can be budgeted as operating expense against income from the apparatus.

Your G-E x-ray representative will be glad to give you facts and figures. Or write to X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, for Pub. H-11.

Progress Is Our Most Important Product

GENERAL ELECTRIC

for superior performance and precision fit



B-D YALE® NEEDLES

sharp—uniform—safe

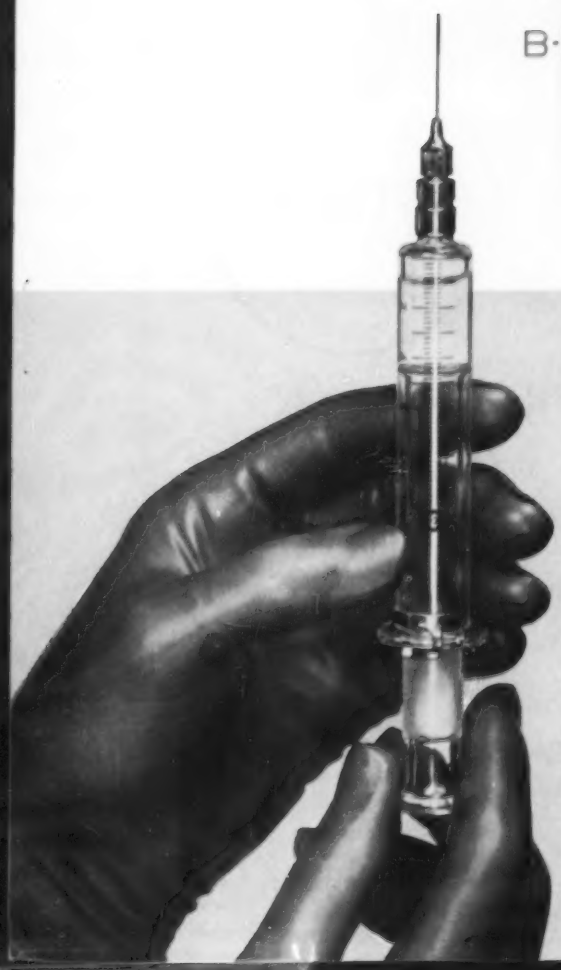
- rust-resistant throughout
- hold a sharp point
- minimize tissue trauma

with

B-D MULTIFIT® SYRINGES

every plunger fits every barrel

- fewer replacements
- longer life
- more convenient handling



BECTON, DICKINSON AND COMPANY • RUTHERFORD, N. J. B-D

B-D, MULTIFIT, AND YALE, T. M. REG. U.S. PAT. OFF.

consider cost, comfort—complete satisfaction

SELECT *Faultless* EPIDERM SURGEON'S GLOVES

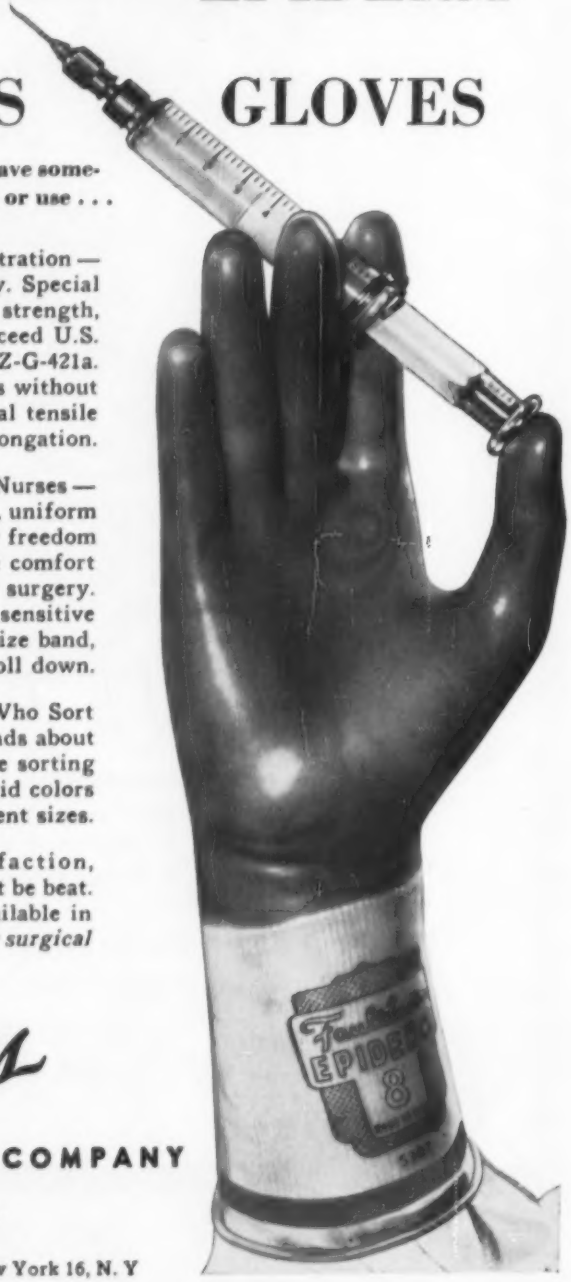
Faultless epiderm surgeon's gloves have something for all concerned with purchase or use . . .

Faultless for Administration — epiderm gloves save money. Special compounding means unusual strength, tear resistance. Gloves exceed U.S. Government specifications ZZ-G-421a. Stand repeated autoclavings without important loss of original tensile strength, elongation.

Faultless for Doctors and Nurses — anatomically correct shape, uniform gauge throughout glove for freedom of hand movement, complete comfort even during extensive surgery. Tissue thinness for extra sensitive fingertip feel. Color size band, added protection from roll down.

Faultless for Those Who Sort and Pair — bright color bands about 3/8" above glove roll make sorting quick and accurate. Five vivid colors for the different sizes.

For cost, comfort, complete satisfaction, Faultless epiderm surgeon's gloves can't be beat. Made only of the very finest latex, available in white or brown, sizes 6½ to 10. *Ask your surgical supply dealer or write:*



THE *Faultless* RUBBER COMPANY

Ashland, Ohio

Exclusive Sales Representative
Homer-Higgs Associates, Inc., 385 Fifth Avenue, New York 16, N. Y

Erythromycin in treatment of abscess

6/21/55

DISCHARGE SUMMARY

On 5/23/55 this patient (colored female, age 24) underwent an excisional biopsy of a breast tumor. On 5/24 tumor was removed and patient discharged from hospital on following day.

On 6/3/55 patient was readmitted because of purulent discharge from wound. On 6/3 a hemolytic Staph. aureus (coag. +) was isolated from abscess with the following disk sensitivities: penicillin, 1.5 units; erythromycin, 10 mcg; tetracycline, 10 mcg. Patient was placed on penicillin, 600,000 units b.i.d. for 10 days. On this schedule patient improved but progress was unsatisfactory and wound continued to discharge small amount of purulent material.

On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

Final diagnosis: breast abscess due to Staph. aureus.

Result: rapid and complete recovery on erythromycin following failure of penicillin.

Communication to Abbott Laboratories.

specific against coccic infections

Now, you can prescribe an antibiotic (*Filmtab* ERYTHROCIN) that provides *specific therapy* against staph-, strep- or pneumococci. Since these organisms cause most bacterial respiratory infections (and since they are the very organisms most sensitive to ERYTHROCIN) doesn't it make good sense to prescribe ERYTHROCIN when the infection is coccic?

filmtab®

Erythrocin®
(Erythromycin, Abbott)
STEARATE

with little risk of serious side effects

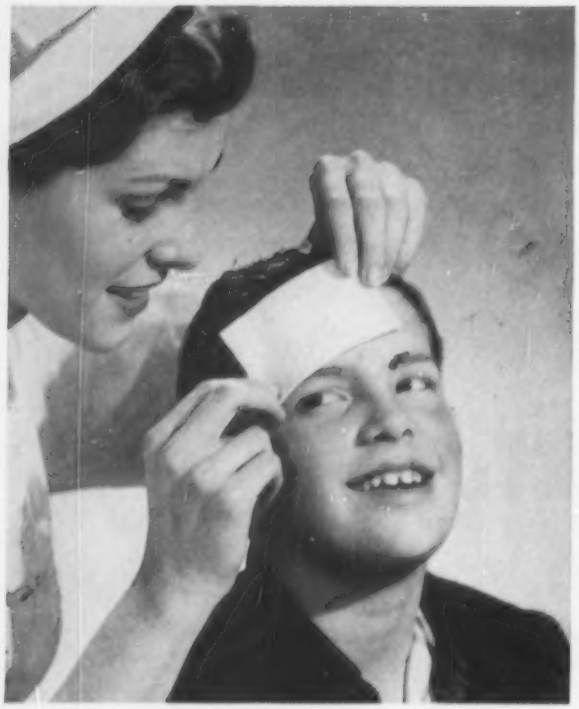
Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to alter intestinal flora—with an accompanying low incidence of side effects. Also, your patients seldom get the allergic reactions sometimes seen with penicillin. Or loss of accessory vitamins during ERYTHROCIN therapy. *Filmtab* ERYTHROCIN (100 and 250 mg.), bottles of 25 and 100. Abbott

filmtab®

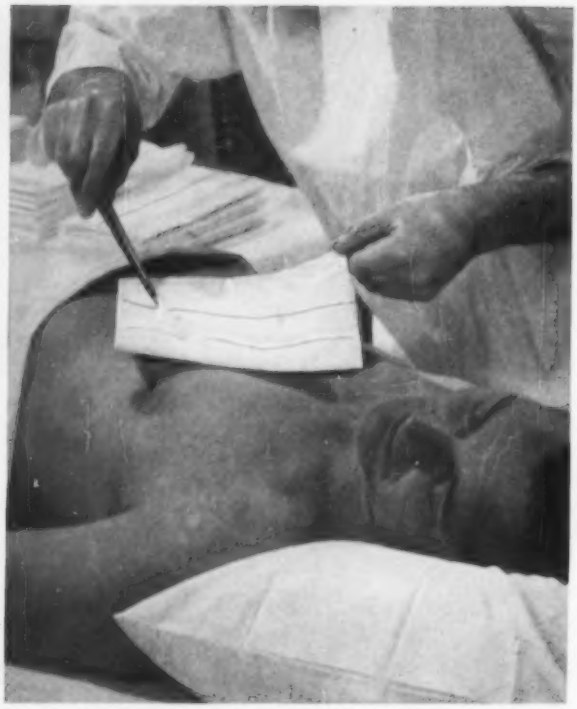
Erythrocin®
(Erythromycin, Abbott)
STEARATE

*Filmtab—Film sealed tablets; patent applied for.

OUT-PATIENT . . . OR . . . IN-PATIENT



FOR MINOR WOUNDS, TELFA *Strips* provide ample absorption with easy, painless removal. Three convenient sizes—and they can be cut to fit any wound. TELFA permits fast, primary healing—at lower cost.



FOR MAJOR SURGERY, TELFA *Sponge-Pads* provide maximum absorption, retentiveness and protection from trauma and contamination. Yet dressing lifts off easily—healing tissue and stitches are undisturbed.

USE TELFA WHEREVER WOUNDS ARE DRESSED

to speed healing, cut dressings costs

For routine use on all wounds... absorbs without sticking, lifts off painlessly

Wounds that you now dress with gauze, or with sponges and pads, can be dressed *better* and *more economically* with TELFA. This is one case where it actually costs less to use the best.

You can now standardize on TELFA in all departments—and cut dressings costs from 18% to 41%—because TELFA is now in 2 forms to meet all wound needs.

There are TELFA *Strips* for simple, minor wounds—including a large size for plastic surgery; and TELFA *Sponge-Pads*, for all routine surgical wounds and even for drainage cases. It is the first complete dressing in a single "unit."

But the saving is even greater for the simpler dressing technic reduces doctor and nurse time in all departments by 50% or more.

Because of its perforated "plastic skin" that goes next to the wound, TELFA absorbs drainage without sticking to the wound or stitches. No interference with *natural healing* because TELFA is inert—unmedicated, no grease to complicate later treatment.

Result: you get fast, *primary* healing . . . less patient discomfort.

TELFA Strips in bulk cases 2½" x 4", 3" x 8" and 8" x 10".

TELFA Sponge-Pads in bulk cases 4" x 5" and 5" x 9" pads.

Curity
REG. U.S. PAT. OFF.

TELFA®

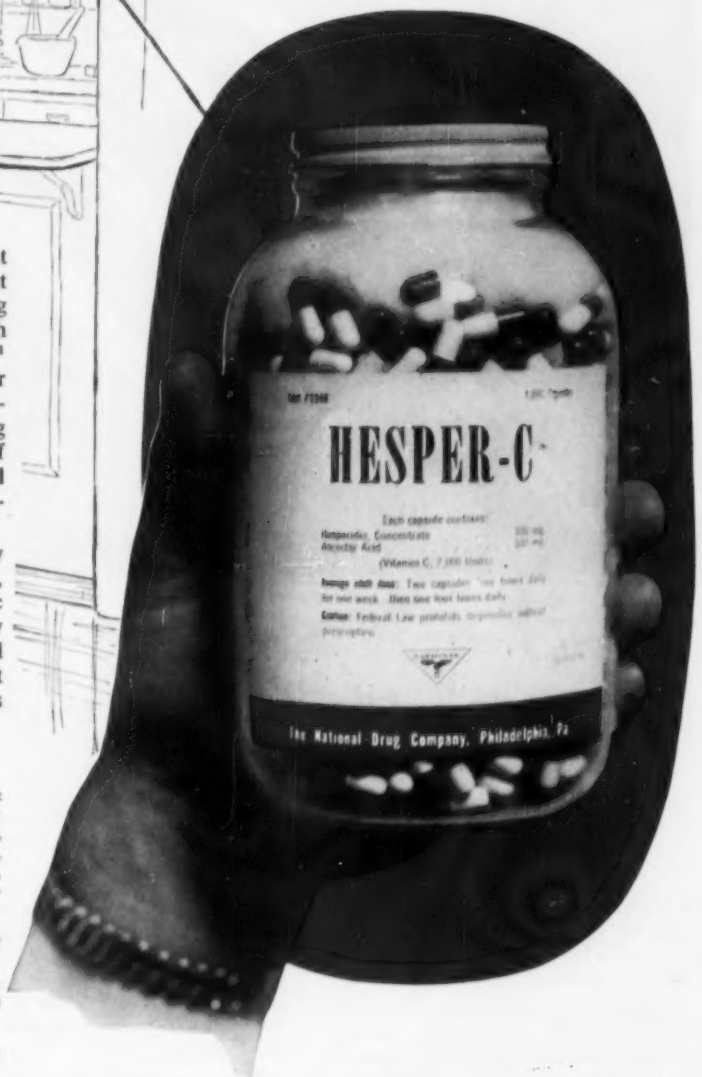
NON-ADHERENT
STRIPS OR
SPONGE-PADS

BAUER & BLACK
DIVISION OF THE KENDALL CO., CHICAGO

A DESERVING PLACE in the HOSPITAL PHARMACY

HESPER-C

for CAPILLARY INTEGRITY MAKES the DIFFERENCE



Maintenance of capillary status is an important consideration in integrated management of most hospitalized patients. Increasingly, it is being recognized – "there is no disease state in which the capillaries are not detrimentally modified."[1] Capillary integrity is a determinant in cellular or body resistance to the stresses causing hospitalization. Hesper-C is a means for controlling capillary fragility, important for retardation of progression in many disease states. Such control can increase the spread between disease, disability and disaster.

To assure the most favorable prognosis in any therapeutic regime for the hospitalized patient, Hesper-C should be considered as a basic adjuvant to treatment. Prevention of capillary fault and restoration and maintenance of normal capillary permeability will help prevent hemorrhage and loss of essential tissue nutrients and metabolites.

HESPER-C will make the difference in management of these hospitalized patients: hypertensive, diabetic, cardiovascular, asthmatic, allergic, urinary infection, upper respiratory infection, liver disease, epistaxis, thrombophlebitic, traumatic, retinopathic, pre- and post-operative, patients on anticoagulant therapy, patients on roentgen therapy.

DOSAGE: Initially 6 capsules or more per day for the first week. Then 4 capsules daily.

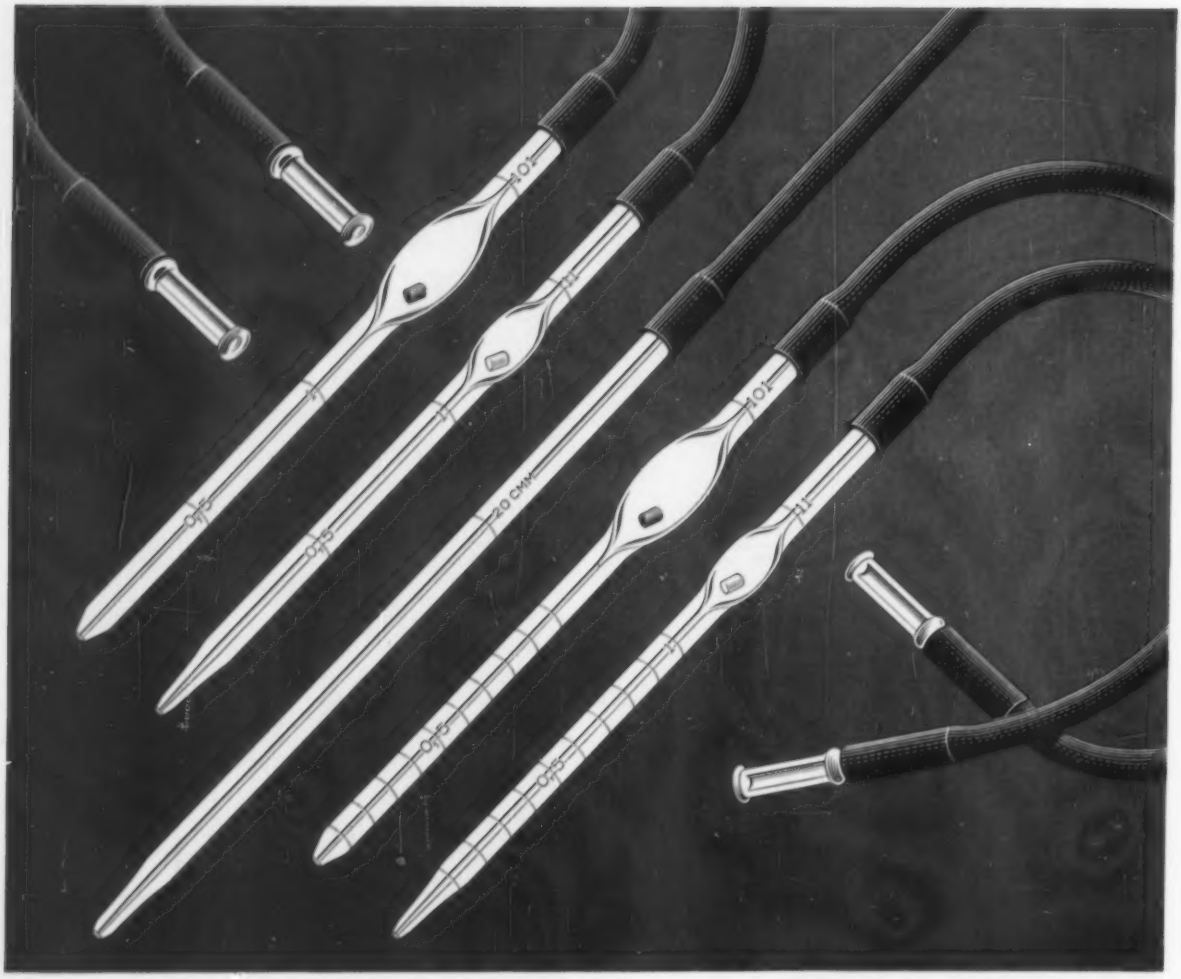
SUPPLIED: Hesper-C (hesperidin 100 mg. and ascorbic acid 100 mg.) capsules are available in bottles of 100 and 1000.

REFERENCES: 1. Martin, G. J. (Editor): Hesperidin and ascorbic acid, naturally occurring synergists. Basel, Switzerland. Messrs. S. Karger, 1954.

PRODUCTS OF ORIGINAL RESEARCH

NATIONAL NATIONAL NATIONAL NATIONAL NATIONAL NATIONAL

THE NATIONAL DRUG COMPANY PHILADELPHIA 44, PA



#823 and #824—3-line Blood Diluting Pipettes for red and white corpuscles; #827 Sahli Blood Diluting Pipette; #825 and #826—11-line Blood Diluting Pipettes for red and white corpuscles.

The markings are permanent... the prices reduced *on all Glasco Blood Diluting Pipettes*

Only the price has been changed—the quality is higher than ever. These Glasco Blood Diluting Pipettes are made to the most rigid standards.

They are accurate—All markings are indicated with a permanent, fused-in colored material. This filler is as resistant to chemical attack as the pipette glass itself. Tubing used for pipettes has uniform bore. This permits uniform spacing of graduation lines... accuracy throughout graduated length. Accuracy is kept within limits set by the National Bureau of Standards: ±5% on pipettes for red corpuscles; ±3.5% on pipettes for white corpuscles; ±3% for Sahli pipettes.

They are completely annealed—All pipettes are carefully and scientifically annealed and all have *permanent*, fused-in filler for day-in, day-out hospital use, and to give them greater life expectancy.

Glasco Pipettes are available with either 3-line or 11-line graduations.

At the old price these instruments were an excellent value. At their new lower prices they are an exceptional bargain. Your hospital supply house has them in stock now. Call today.

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

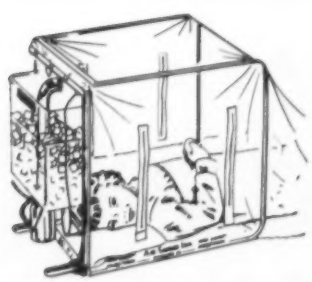
WHY *the* CROUPETTE® OUTPERFORMS all other croup tents

PATIENT COMFORT AND SAFETY FEATURES

	CROUPETTE	*Tent "A"*	*Tent "B"*	*Tent "C"*	*Tent "D"*
1. Recirculation of tent atmosphere	Yes	No	Yes	No	No
2. Cooling	Forced circulation	Convection only	Convection only	No cooling	Convection only
3. Free of interior obstructions	Yes	No	No	No	No
4. Ice chamber and drain inaccessible to patient	Yes	No	No	No cooling	No
5. Pressure connection inaccessible to patient	Yes	No	No	No	Yes
6. Water supply inaccessible to patient	Yes	No	No	No	Yes

CONVENIENCE AND NURSING FEATURES

	CROUPETTE	*Tent "A"*	*Tent "B"*	*Tent "C"*	*Tent "D"*
1. Quick and easy set-up and disassembly	Yes	No	Yes	No	No
2. Access to patient	Four side zipper openings	Down from top only	Down from top only	Down from top only	Down from top only
3. Filling of ice chamber	Outside	Inside	Inside	No cooling	Inside
4. Refilling of water supply	Outside	Inside	Inside	Inside	Outside
5. Mist apparatus integral part of tent	Yes	No	Yes	No	No
6. Storage compactness	Yes	No	No	No	No



3,000 hospitals and 96 per cent of all U.S. medical schools have 1 to 36 CROUPETTES in use, providing cool vapor therapy—with or without oxygen—for pediatric patients.

For complete information write

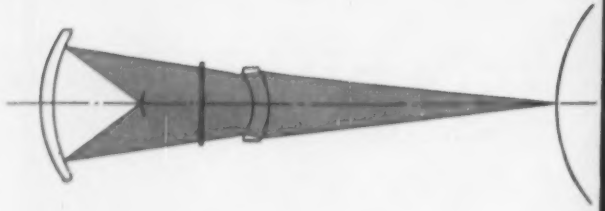
AIR-SHIELDS, INC.

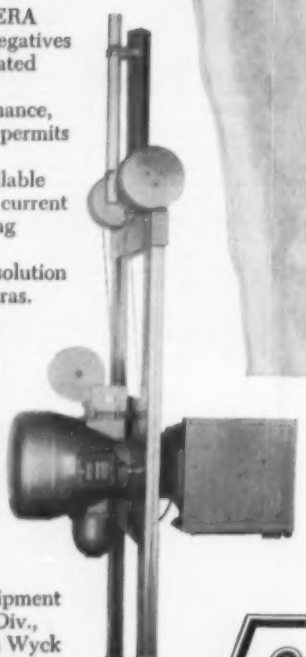
HATBORO, PENNSYLVANIA

New concentric mirror optics give

DIRECT X-RAY QUALITY in 4″x4″

photofluorography





THE NEW FAIRCHILD-ODELCA 4 x 4 CAMERA brings, for the first time, top-quality diagnostic negatives produced on 4″ x 4″ film — in a camera fully evaluated for general radiography.

The heart of this camera's exceptional performance, the Bouwers Concentric Mirror Optical System, permits an extremely wide working aperture of f/0.7 (GRA f/0.65). Speeds four to five times that available in refractive lens cameras permit much lower tube current and 75 to 80% reduction in exposure time — resulting in substantially reduced radiation.

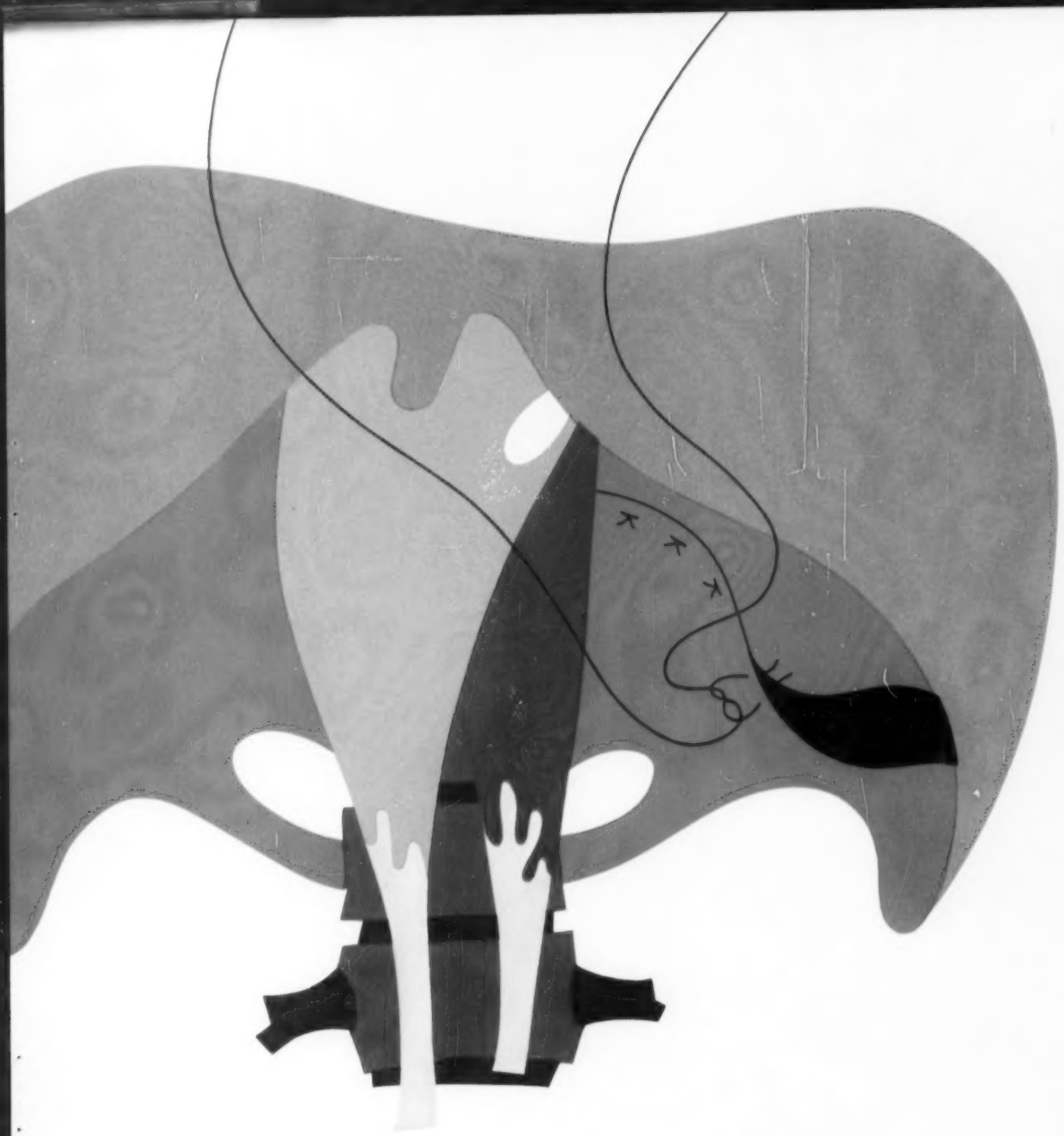
The concentric mirror optics provide a gain in resolution as much as four times that of refractive lens cameras. Retakes are eliminated because both voluntary and involuntary motion are stopped. Designed for under-table, over-table and upright use. The small film size, of course, provides great economies in purchase, handling, processing and storage.

The complete line of Fairchild-Odelca Cameras covers the four major categories of photofluorography; mass chest survey . . . hospital admissions X-ray . . . serial radiography . . . and now even general radiography. Three models are available: the new 4″ x 4″ model (illustrated), the 70mm In-Line model and the 70mm Angle-Hood model.

Get complete details from your regular X-ray equipment supplier, or direct by addressing Industrial Camera Div., Fairchild Camera and Instrument Corp., 88-06 Van Wyck Expressway, Jamaica 1, N. Y., Dept. 160-41P.

FAIRCHILD

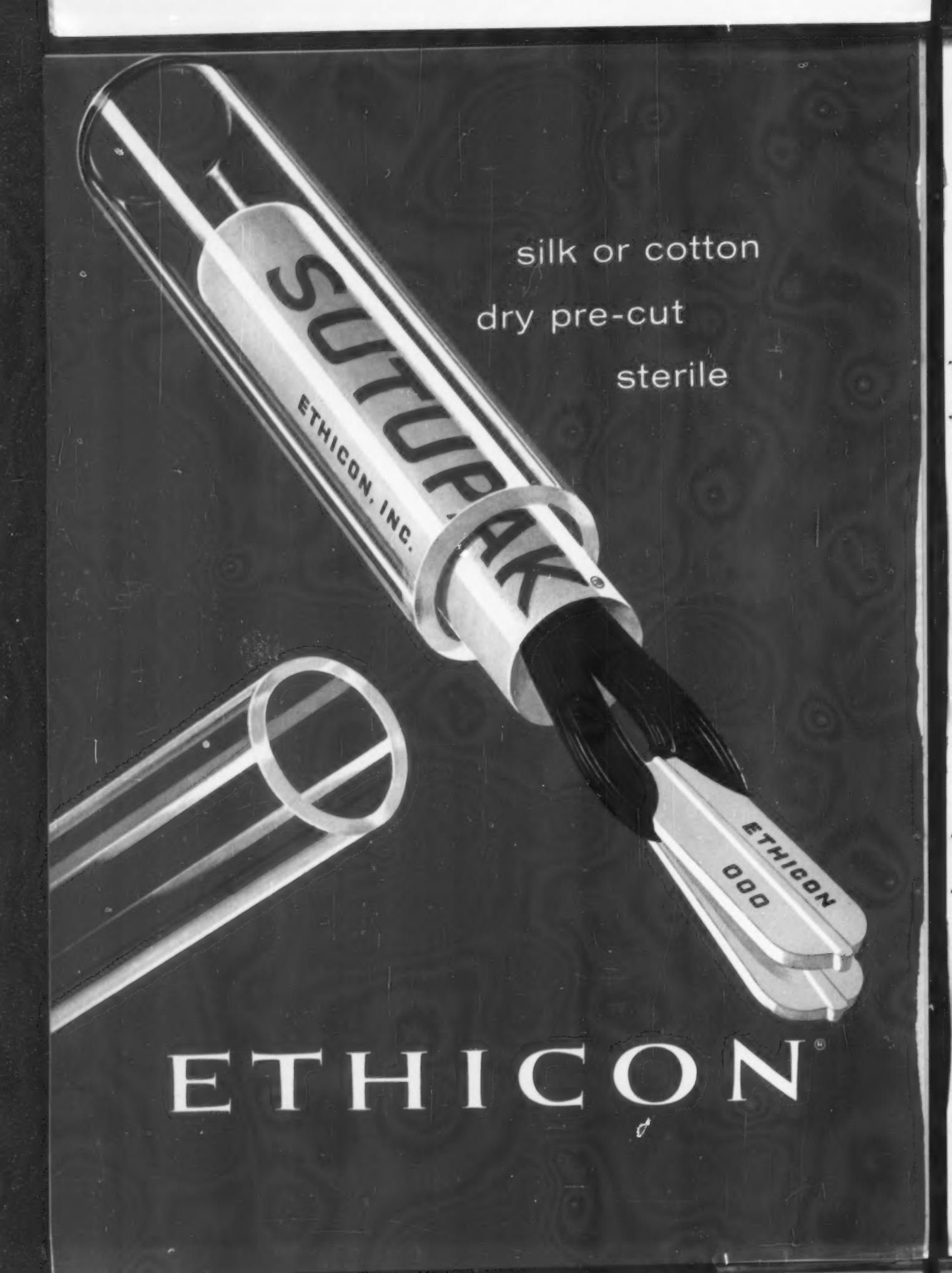
X-RAY CAMERAS AND ACCESSORIES



setting new standards

ETHICON®

sutures


SUTUPAK®
ETHICON, INC.
ETHICON
000
silk or cotton
dry pre-cut
sterile
ETHICON®

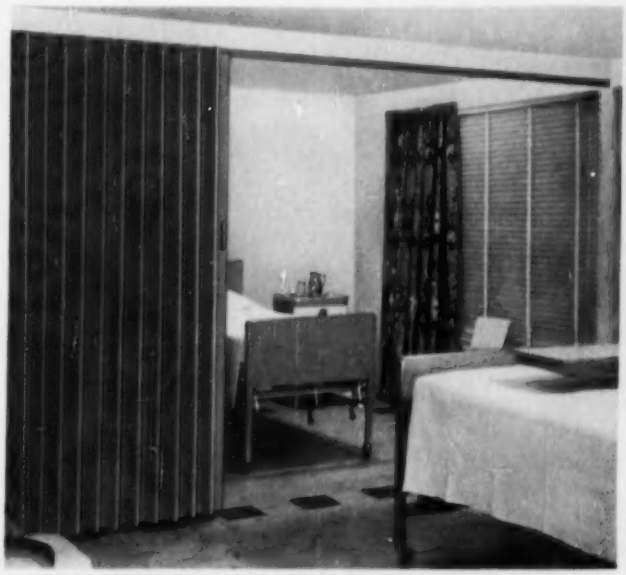
Like to get the capacity of two rooms in the space of one?

Modernfold doors quickly divide multiple rooms or wards into semi-private rooms

MODERNFOLD Doors increase your capacity at low cost, and *still* give every patient the privacy and quiet that he needs.

These doors fold or unfold in *seconds* to give you space custom-tailored to your needs at any moment.

They're rugged, easily washed and come in dozens of cheery colors. Consult your MODERNFOLD distributor; from the initial planning to final installation, he can help you to use your space more efficiently.



Mounted on overhead tracks, a MODERNFOLD Door can double the capacity of this private room almost instantly. When not needed, it folds compactly away.

Here MODERNFOLD can make space more versatile... save on costly remodeling.

NEW CASTLE PRODUCTS, INC.
Dept. A57, New Castle, Indiana
(In Canada, New Castle Products Ltd., Montreal 6)

Please send me full information on MODERNFOLD Doors.

NAME _____

BUSINESS ADDRESS _____

CITY _____ ZONE _____ STATE _____

modernfold ®
DOORS

MODERNFOLD Distributors are listed under "Doors" in city classified telephone directories.

New Velva-Soft® gives to all washables

New Armour discovery gives all fabrics you wash a luxurious, soft finish! Makes whites whiter, colors brighter. Actually softens, blues and brightens in a single rinse for just pennies a load!

Now VELVA-SOFT, the miracle fabric softener, has new BLU-BRITE added—Armour's exclusive combination fabric blue and brightener. Makes VELVA-SOFT the only product in the world that softens, blues and brightens everything you wash—does all three in a single rinse! Towels come out nearly twice as thick and fluffy. Muslin sheets become as smooth as percale. All white goods come out gleaming and snowy white, and colors are brighter than ever! What's more, fabrics actually last longer, wear better when they're rinsed in new VELVA-SOFT!

New VELVA-SOFT with BLU-BRITE makes laundering operations much easier, too! A VELVA-SOFT finish resists dirt, grease, food and body stains, so fabrics come clean quicker—you'll have fewer re-runs. VELVA-SOFT works equally well on *all* fabrics—natural and synthetic. And VELVA-SOFT treated fabrics are practically static-free, almost wrinkle-free. That makes the shake-out period shorter and ironing easier.

All these amazing VELVA-SOFT benefits require no extra work. You simply add new VELVA-SOFT with BLU-BRITE to your final rinse! And since it is the *final* rinse, none of the softening, bluing and brightening powers are washed away.

Diapers and surgical linens are softened and sanitized! New VELVA-SOFT containing BLU-BRITE sanitizes as it softens diapers. Diaper rash bacteria (bacillus ammoniagenes) are stopped before they can cause irritation. Surgical linens maintain this sanitized treatment from one wash to the next.

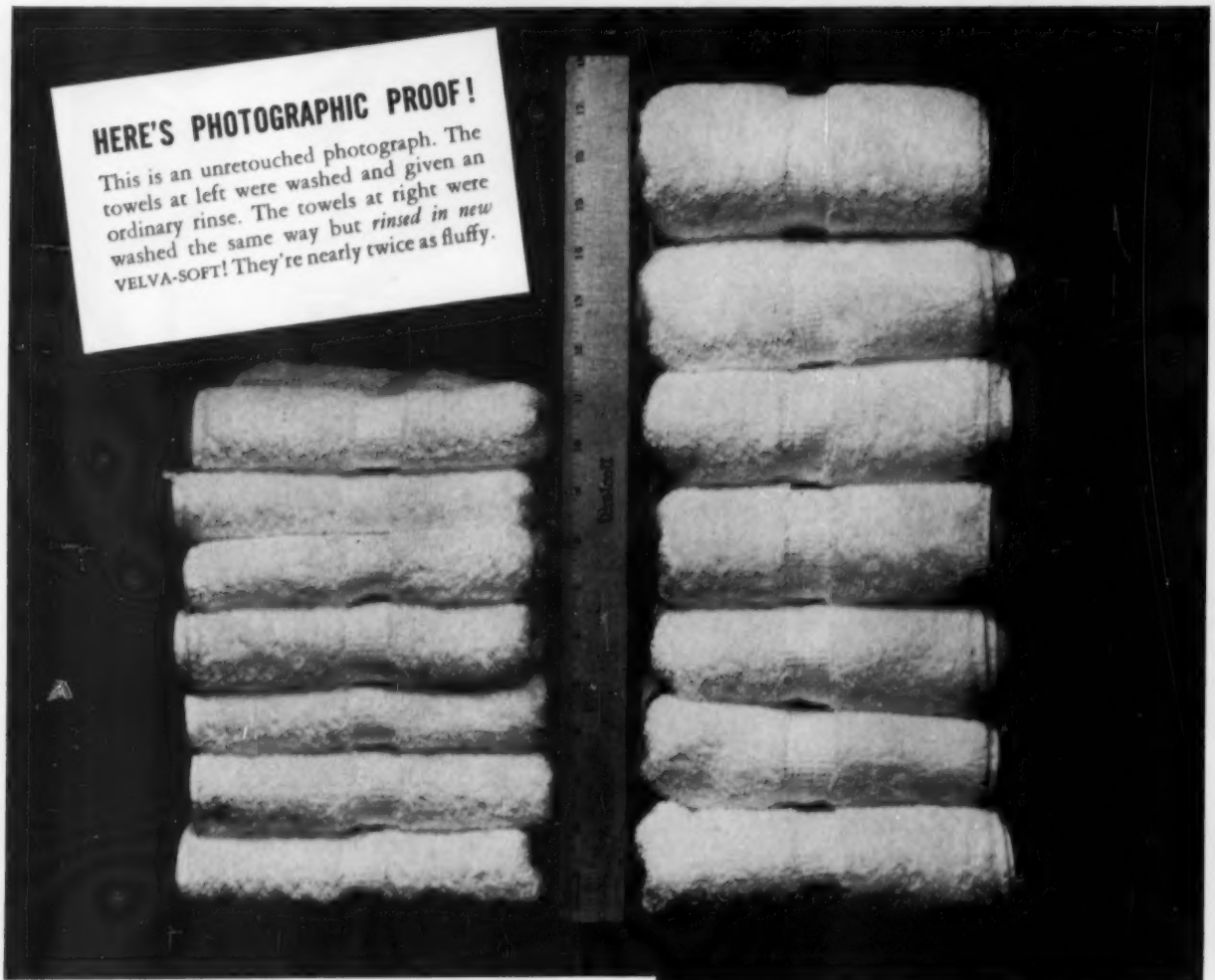
Send for a trial order, today. See for yourself the amazing difference a VELVA-SOFT rinse can make!

Muslin Sheets Feel Like Percale!
New VELVA-SOFT softens fibers and gives fabrics a smooth, soft finish. Makes even the roughest muslin sheets feel as smooth and luxurious as percale!

Makes Ironing Much Easier!
Fabrics treated with new VELVA-SOFT are practically static-free—almost wrinkle-free. VELVA-SOFT finished clothes shake out faster—folding is easier!

Gives Fabrics Longer Life!
A VELVA-SOFT finish keeps dirt and grit out of fibers—restores natural flexibility and lubricity. Reduces stiffening, fraying, breaking of fibers—mechanical wear of fabric!

a soft, fluffy finish -brightens and blues, too!



ARMOUR *Soap Division*
INDUSTRIAL SOAP DEPARTMENT

© Armour and Company • 1355 West 31st Street • Chicago 9, Illinois

Mail this coupon today!

Armour Industrial Soap Department, M1
1355 West 31st Street, Chicago 9, Illinois

Please send me:

- ☐ Free VELVA-SOFT booklet and price information.
- ☐ Trial Order (with a money-back guarantee!) of new VELVA-SOFT with BLU-BRITE—125 lb. drum @ $27.50.

☐ Check ☐ Money Order ☐ Bill me

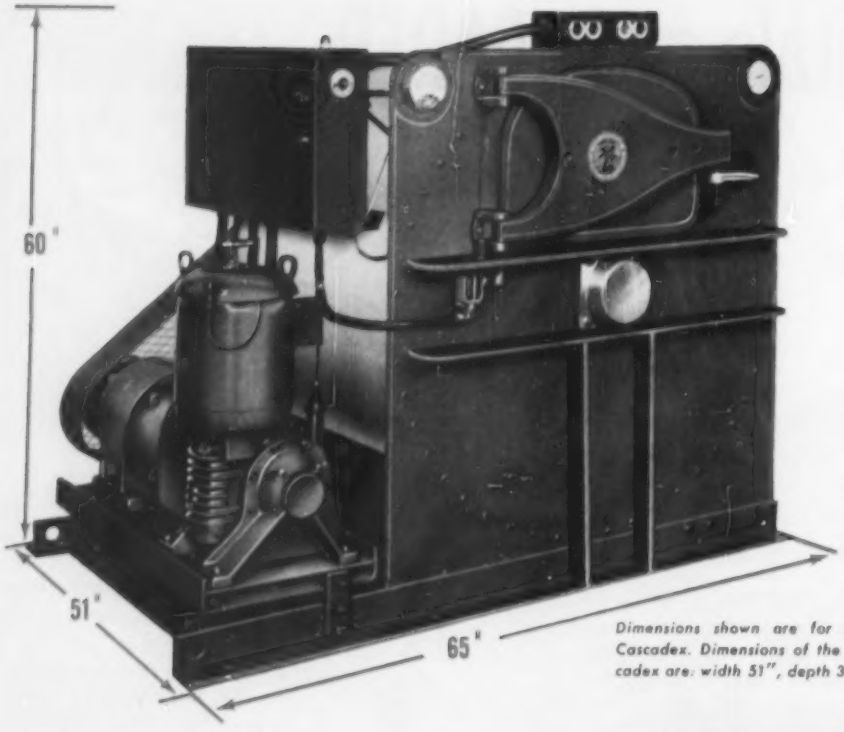
Name .....

Address .....

Firm .....

City ..... Zone ..... State .....

now! hospital laundries can



Dimensions shown are for the 40 x 30" Cascadex. Dimensions of the 32 x 24" Cascadex are: width 51", depth 39", height 55".

EXCLUSIVE INTERMEDIATE SPEED!

While wash baths are draining from the Cascadex, the cylinder automatically goes into *non-reversing intermediate* speed before accelerating to extraction speed. This not only reduces the starting load on the Extract motor but also distributes work evenly in the cylinder prior to extraction, assuring smooth acceleration to extracting speed.

That is why the Cascadex requires no complicated balancing mechanism or massive foundation, making it such a simple machine that it can be installed *in any normal location in all types of laundries.*

Here is easy, waist-high loading and unloading. A separate hinged door for each cylinder compartment opens downward, bridging the gap between cylinder and front tub head, serving as an excellent unloading apron. Available with either horizontal or Y-pocket cylinder.

save:

labor, floor space, transfer time, machine investment, supplies

Saves equipment investment by combining washing and extracting in one compact machine.
Saves labor since only one machine need be attended instead of the usual two.
Saves floor space with greater production per square foot of floor space compared to separate washer and extractor of same load capacity.
Saves operating time by eliminating necessity of transferring wet work from washer to extractor.
Saves water by extracting between rinses. Only half as many rinses are required as in conventional washer.
Saves production time by reducing number of rinses normally required, and by speeding up draining of baths, thus shortening washing time per load.

wash and extract in one machine!

MANUALLY OR AIR-OPERATED MODELS IN TWO SIZES:—

32x24" (50 lbs. dry wt. capacity)

40x30" (100 lbs. dry wt. capacity)

The American Cascadex Washer-Extractor is furnished either manually-operated, or air-operated for use with an Automatic Washing Control.

The air-operated Cascadex is equipped with air-actuated hydraulic brake and outlet valve. The tub door is air sealed and air interlocked.

The manually-operated Cascadex is equipped with treadle-applied hydraulic brake, treadle-operated outlet valve, manually sealed and mechanically interlocked tub door.

The American Cascadex Laundry Washer-Extractor incorporates the experience gained in over 30 years developing and building quality washer-extractors for the dry cleaning industry. As a result, American now offers you a *laundry* washer-extractor that will cut costs for you in every phase of laundry washing and extraction.

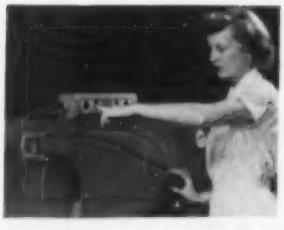
To assure its utmost operating efficiency and performance under all kinds of conditions, the Cascadex was field tested over a 3-year period in more than 50 laundry plants of all types.

The Cascadex Washer-Extractor joins the long list of American-pioneered products and methods which have benefited laundries of all types for more than 87 years. To name a few: Cascadex Automatic Unloading Washer, Cascade Full-Automatic Control, Notrux Mechanically Loaded and Unloaded Notrux Extractor, Formatic Shirt Unit, Trumatic and Foldmaster Automatic Flatwork Folders, Stackrite Stacker, and Mechanized Flatwork Ironing.

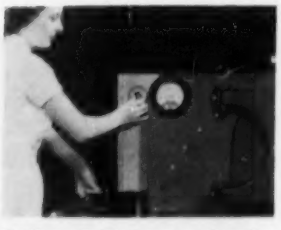
World's Largest, Most Complete Line of Laundry and Dry Cleaning Equipment

American

The American Laundry Machinery Company, Cincinnati 12, Ohio



Notice fast-action, fingertip push-button control station. Control panel is provided with "Start" and "Stop" buttons and two "Inch" buttons for easy "spotting" of cylinder doors in loading and unloading positions. Cylinder doors have foolproof snap latch for firm, sure closing.



Shifting Clutch Lever and setting Timer for the extraction cycle is an effortless job. Length of extraction cycle is controlled by manually-set mechanical Timer with Red Signal Lamp mounted on Reversing Control Cabinet. At end of extracting time, the Signal Lamp lights.

You can depend on your American Representative's advice in your selection of equipment from the *complete American Line*. Backed by 87 years' experience in planning and equipping laundries of all types, he can help solve any laundry problems you may have. Ask for his specialized assistance anytime . . . no obligation.

MAIL COUPON FOR MORE INFORMATION,

ALM 361

The American Laundry Machinery Co.
Cincinnati 12, Ohio

☐ Please send Catalog AB-331-702 which will give me complete details on the American Cascadex Laundry Washer-Extractor.

☐ Please have Representative call.

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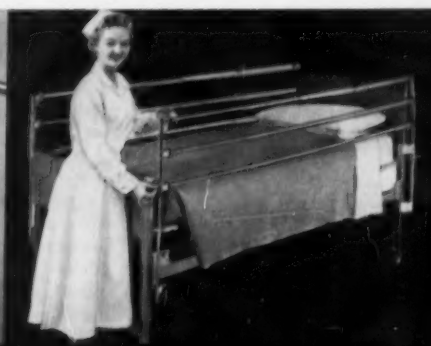
Hospital personnel will be happy to know that they no longer need be plagued by cubicle curtains and safety sides that are unwieldy, difficult to handle, and always in the way.

Continuing product research by American Hospital Supply has developed new TOMAC Cubicle Curtains and TOMAC Safety Sides that telescope conveniently and completely out of the way when not in use. They're lightweight—easy to operate—and ruggedly constructed for years of service. They are proving to be a boon to hospital personnel and patients.

These two outstanding products are successful examples of American Hospital Supply's constant effort to ease the work of hospital staffs and to increase over-all efficiency.

These two products carry the TOMAC symbol—and the TOMAC symbol is always your guarantee of the best equipment in the field.

Telescopes to ⅓ its full length and folds flat against wall when not in use. Easily detached to be moved or stored. Strong, but slender, chromium unit. Linene curtains or Bates curtains are available in five harmonious pastel colors —white, rose, aqua, gray, or blue.



TOMAC Telescopic Safety Sides shown fully extended. Nurse is tightening thumb screw which holds sides securely. Lightweight and convenient, yet ruggedly constructed. Specially designed clamps allow TOMAC Safety Sides to be fitted to all standard beds.

Sides shown telescoped and folded back . . . chain catch prevents sides from opening. Easily and quickly attached without tools. They can be stored or can be left on bed ready for instant use (either at side or behind bed). Rubber bumper prevents marring of walls.

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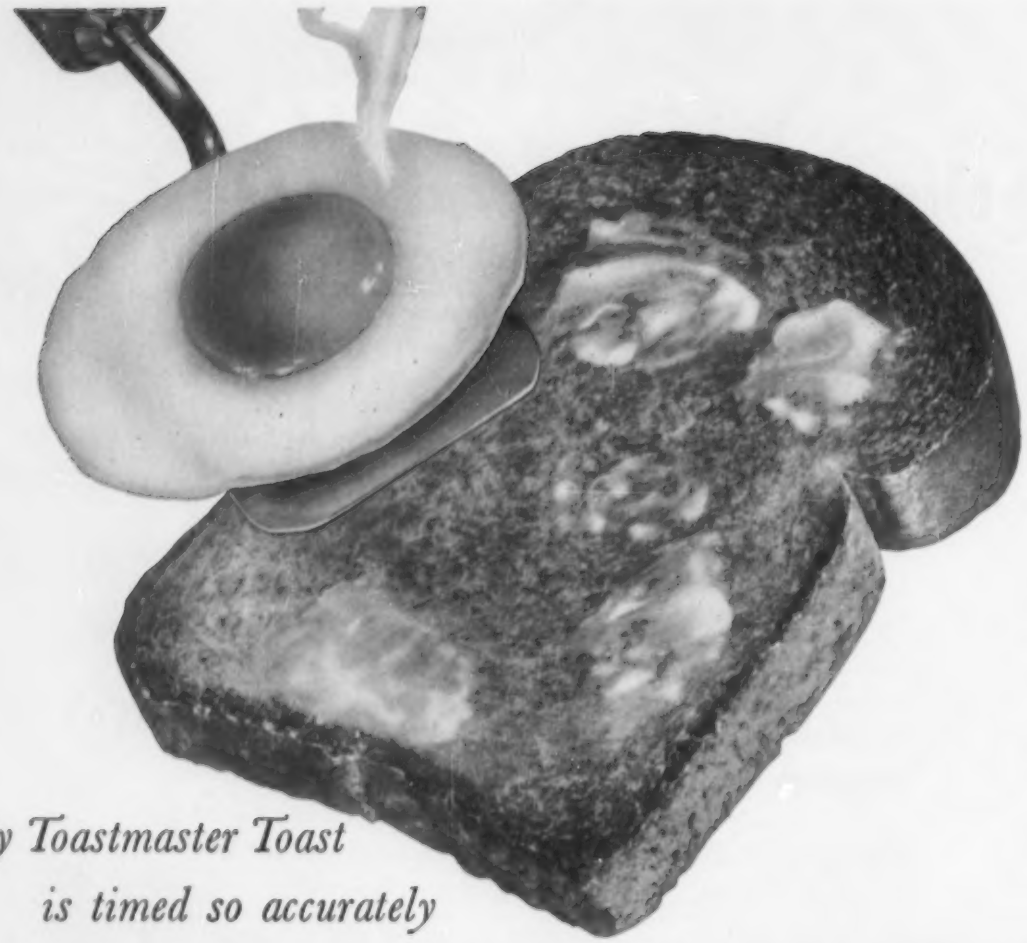

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ITS GOLDEN GOODNESS NEVER VARIES!

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Patients respond (even as you and I) to such appetite appeal as this! There's just nothing like Toastmaster Toast! Every slice is such a tantalizing golden-brown—so crunchy, tender and delicious. And this is true whether you make one or one-thousand slices daily!

The new Superflex Timer toasts fast when cold, faster when hot, giving every slice the same golden-brown feature. And, it automatically compensates for voltage fluctuations, assuring you of perfect toast uniformity on every operation.

Accuracy is just one of many advantages of this all-new "Toastmaster"* Powermatic Toaster. Its Powermatic feature, *no levers to press*, saves time and labor, cuts wear and tear. This is also the most flexible toaster. Compact in size, it fits where needed. Available in 2, 4, 6, 8, 12 and 16-slice models.

Ask your restaurant equipment dealer to demonstrate the speed, accuracy and flexibility of the superb new Powermatic toaster.

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4-Slice Model
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ALL-PAPER SERVICE IS MOST ECONOMICAL WAY TO FEED PATIENTS!

...and patients like paper because it's decorative, quiet and easy to handle!

DIETITIANS PLEASE READ!

An extensive survey dealing with the use of paper cups and containers in hospitals disclosed some remarkable facts. For example, the years-old idea that paper service for patient feeding was too expensive was completely dispelled. In fact, several leading hospitals learned *it actually costs less to feed patients with all-paper service than with conventional ware.*

ONLY 5c PER MEAL!

In hospitals with a Cost Accounting System that permitted accurate comparison of paper service with china and glassware, the *average cost per patient per meal when served in paper cups, containers, dishes and plates was approximately 5c!*

WHY PAPER COSTS LESS!

(A) — Less Labor! — No dishwashing, sterilizing, stacking away! Fewer trips to and from the kitchen.

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Adlake 99th year of serving the transportation, building and control industries

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SMALL HOSPITAL QUESTIONS

Wage Scale for Employes

Question: This is a general hospital with a bed capacity of 230, with 42 bassinets. We have here close to 200 employes and, for the care of patients, we have graduate nurses, licensed practical nurses, nurse's aides and orderlies. We would like to know whether or not job evaluation and merit rating on employes would be a worth-while project to establish in a hospital. In the event that you would approve of such a system, we will appreciate your giving us some information which would help us to begin this job evaluation and merit rating system.—Sr. M.C., S.D.

ANSWER: The first requisite for the establishment of any scheme of compensation is full and detailed knowledge of the requirements of the jobs for which compensation is to be provided. Step No. 1 in that direction is an actual job-by-job review of the specifications or duties in each position. This is sometimes done by a reviewing officer or committee that by actual observation sets down the details. This method has the advantage of objectivity and of a common standard of approach and point of view, but it is usually cumbersome; it takes some time to complete the review of a large number of jobs and is hence expensive. The more usual first step is to furnish to each employe an information blank on which he provides details about the tasks he actually performs and proportionate time spent in their performance and to provide space on the same blank for additional comments of agreement or disagreement by the immediate supervisor.

Step No. 2 is to group together under single headings individual jobs which are sufficiently similar to justify common identification titles and salary ranges, to write up brief one or two sentence definitions of each, accompanied by a more extensive list of "duties by example," and to set down minimum qualifications which should be possessed by an applicant before he can be considered for employment in this type of position.

The end result of the accomplishment of these two steps should be a list of position classifications which provide concise statements as to job requirements and performance standards. Within this list of *classifications* should be included all *positions* found in the hospital. It is *very* important that we differentiate clearly between these two terms and that we understand that when we talk about requirements or compensations of a classification we are speaking of what is required by a *typical* job or position within the classification and that we do not speak of the particular abilities or potentialities of the person filling the position. To use an oversimplified and highly unoriginal example, a Ph.D. may have actual ability and potential value far beyond the requirements of a janitor's position, but if the Ph.D. is doing the work of a janitor his classification is that of a janitor, and on it is based his rate of compensation.

It is entirely proper to have a minimum and maximum allowance within which we can compute compensation for a job, position or classification, but if these amounts honestly represent the value of a job, position or classification, pay for all of those so classified should be within the specified range, with variations within that range being used in accordance with length of service, aptitude and merit.

Following this classification, every effort should be made to establish pay scales which are (1) consistent as between each other and (2) competitive as to comparable positions in the surrounding community. The acceptance of the principle of "prevailing practice" is unavoidable, though whether the highest, the lowest, or the average is chosen as "prevailing" depends a good deal on the resources of the individual hospital.

Ranges should be established for classifications in which varying degrees of experience and ability are found. Single rates may be more appropriate for classes where individual differences in performance and qualification are not important.

There is a further and rather exact technic known as evaluation which enables an institution to measure the value of different positions by the consideration of four basic factors: (1) preparation required for the job, (2) personal qualifications required for the job, (3) responsibility required on the job, (4) conditions surrounding the job.—DONALD E. DICKASON, *director of nonacademic personnel, University of Illinois.*

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Sterilizing Syringes

Question: We sterilize syringes by boiling rather than autoclaving, and one of our doctors has insisted this procedure involves a risk of transmitting hepatitis and other infections. We have not had any infections of this kind as yet, but wish to be sure our procedure is safe. What is recommended?—M.D., Fla.

ANSWER: A recent report of the committee on hepatitis of the World Health Organization, published at Geneva, Switzerland, in March 1953, reads as follows: "Syringes, needles or other instruments must be thoroughly washed in water immediately after use to prevent organic material coagulating or drying on the surfaces of the instruments and interfering with the effect of subsequent sterilization. The following methods of sterilization are acceptable: boiling in water for at least 10 minutes, steam under raised pressure (autoclave), and dry-heat sterilization (hot-air oven). If the temperature can be properly controlled in all parts of the hot-air oven, treatment at 348°F. for half an hour is adequate, otherwise treatment at 356°F. for one hour is recommended. Lancets and other instruments used for capillary-blood sampling and scarification may be sterilized in an open flame after washing in cold water."

According to this internationally accepted standard of the W.H.O. committee, your procedure is safe provided the syringes are adequately cleaned in advance of sterilization and provided they are boiled for a minimum of 10 minutes.

wire from Washington

JOINT USE OF MILITARY HOSPITALS

Defense Department, partly in response to urgings from backers of the Hoover Commission, has ordered a reform in its hospital program that could result in important savings in money and manpower. It will be a few months before it is clear whether it's a paper change only, or has the support of the three medical departments.

The department has instructed army, navy and air force to make joint use of all military medical facilities, and to coordinate any new construction to take advantage of this new policy. The order also calls for the services to keep each other informed of medical research programs, and of preventive medicine and laboratory progress.

One sentence in the directive is evidence that not too much unification is desired at this time. It says: "Joint utilization as used herein is not to be construed as joint staffing." The exception is the formation of medical teams for the examination of reserves; if the service involved cannot properly staff an examining team, it may be made up of physicians and other trained personnel from the other two services. "Specially trained personnel" may be used by the three services, but only in "specific instances."

Specific provisions include:

1. **"Use of health and medical facilities** and services of one department by one or both of the other departments, and also . . . support by one department to one or both of the other departments to the extent determined in areas as proven by study to be the most economical and efficient."

2. **"Every effort . . . to reduce,** consolidate, or eliminate facilities in specific areas where another facility is available and can economically and efficiently provide the necessary support. . . ."

3. **" . . . Planning for new construction** and major alterations will include consideration of total workload to be performed at the planned facility to provide . . . for all armed forces personnel and their dependents. . . ." The secretary of the department doing the building will be responsible for meeting this requirement.

To get the consolidation under way, Defense Department has instructed the services to transfer to the facility nearest their duty station any patients now hospitalized who are expected to return to active duty, and to transfer to the facility nearest their homes any patients who are not expected to return to duty. In making the shifts the only consideration will be proximity to home or duty station, regardless of which service operates the hospital or clinic.

In estimating operating requirements, the services have been told to base their plans on "optimum joint utilization of facilities." If any significant change is to be made, the service involved is under instructions to coordinate its plans with those of the other two departments.

Although the directive plainly states its objective, a number of qualifications necessarily are included, such as "consistent with the attainment of . . . primary mission," and "maintenance of the state of training, operational readiness, and capability for expansion required for discharge of emergency and wartime missions. . . ." Military medical officials not in sympathy with the unification move can, if they try, find enough justification for obstructionism.

FORD FOUNDATION

There is some question here whether the Ford Foundation's grants of $200 million to private, nonprofit hospitals (see page 58) will stimulate or retard the federal Hill-Burton program for construction grants.

These are some of the factors:

Whether justified or not, Congress may feel that hospitals have had a substantial assist and that they don't need as much H-B money, although leaders of both parties are on record for larger grants.

On the more hopeful side, about half the country's hospital beds are in public institutions which do not qualify for the Ford money, something that certainly will be impressed on Congress.

Actually, there may be an increased demand for H-B grants if enough hospitals decide to use the Ford money to match H-B funds; many hospitals now have enough priority for H-B money, but haven't—or can't—raise the sponsor's share.

Among medical schools, the Ford Foundation's $90 million in grants creates a somewhat similar problem. As among hospitals, only about half the medical schools—those not supported by tax money—will benefit from the Ford money. Furthermore, the medical schools are not privileged to use the Ford grants for construction, as may the hospitals. It must be used to strengthen the teaching staff through better salaries or more job security, or to improve instruction through purchase of new equipment and so on.

In Washington, sponsors of legislation for U.S. aid to medical schools insist that the Ford grants won't mean the end of their hopes. The bill most popular now would allow $250 million over five years for construction and equipment only. Its sponsors say that the Ford grants would merely supplement their bill, and that the two together would get the schools back on a firm financial footing, for now and for the future.

MILITARY DEPENDENTS

Before the end of this month Defense Department will decide whether it should ask Congress to protect military dependents through a nationwide health insurance program

or should propose that the military doctors and military hospitals undertake to do the job.

One thing is certain: The department, with strong White House support, will attempt to get some sort of program enacted this year; whether the service comes from the military medical departments or from private sources, the service families will be offered extensive and uniform protection, at little cost to themselves.

At the request of the Defense Department, Blue Cross and Blue Shield in December made a fast national poll to learn whether the local plans could guarantee full coverage to the families, a type of coverage with which they have had little or no experience.

Preliminary returns indicated that the local Blue Cross and Blue Shield managements were hopeful of meeting Defense Department standards. At the national level, there was not so much optimism in Blue Cross and Blue Shield. There was a feeling that the over-all picture would have enough blank spots to justify Defense Department in going to Congress with a request to give the dependents protection through the military medical departments. An alternative possibility was care similar to that provided under Veterans Administration's "home town fee plan."

If no insurance or direct fee arrangement can be worked out, there is the prospect that the army, navy and air force medical departments will have to expand, and that more military hospitals will have to be built, to take care of the 2 million or more military dependents in this country.

INCOME TAX RULINGS

Hospitals are involved in two recent Internal Revenue Service rulings; they came out fine in one but not so well in the other.

The service decided that if an industrial organization wants to make a gift to a hospital, and not to pay taxes on the money, there must be "no strings attached." In the case in point the company contributed to a hospital building fund with the stipulation that the company employes have preference. The I.R.S. said No, that wasn't a free and open gift. Nor could the company claim the gift as a business expense.

In the other case the service was called on to decide if a community nursing bureau, operated as a community project, qualifies for tax exemption. The nurse bureau in question maintained a nonprofit register of qualified nursing personnel of all types for the convenience of hospitals, physicians and individuals. I.R.S. said Yes, the nursing bureau was tax exempt, because "it is apparent that the purposes and activities of the organization are directed to the relief of conditions relating to the health of the community, which is a matter of public concern, rather than those of a professional society. . . ."

FOOD AND DRUG ADMINISTRATION

For five months early last year a special committee made up of distinguished industrialists, educators and professional people made an inside-and-outside study of Food and Drug Administration.

Last July it recommended reforms along four general lines:

1. **Expand F.D.A.'s** personnel and facilities "threefold or fourfold," provide enough money for a broader program, construct a new Washington headquarters for the agency.

2. **Start an educational** and informational program in the immediate office of the commissioner to ensure a wider distribution of F.D.A. information to the industry, the profession and the general public.

3. **More money** for the legal division to avoid delays in prosecution, and a policy of not instituting actions unless necessary.

4. **Strengthen the headquarters staff** to allow for better programming and internal management.

Without waiting on Congress for the money that may not be forthcoming anyway, F.D.A. now is attempting to put some of the changes into effect. Information and educational operations are being drawn closer together, so efforts in this direction will be more effective. While not admitting that there was any laxity in prosecuting, or in screening the cases, F.D.A. people now are checking up more closely on legal operations, as well as on programming and administrative procedures.

HOSPITAL RESEARCH GRANTS

The first 11 hospital research projects to be approved under the new Research Grants Branch, Hospital Facilities Division, U.S. Public Health Service, were announced last month.

The grants fill a long felt need, Surgeon General Leonard A. Scheele said. Research in hospital administration has been neglected as scientific research has moved ahead constantly in recent years, he added.

Grants approved by the Federal Hospital Council totaled $401,000. The Public Health Service announced the names of the grantees, the directors of investigation, and the amounts of grants.

The grants approved were:

1. **Association of University Programs in Hospital Administration;** Dr. John R. McGibony; $75,000. This is for the development of research programs in the hospital field, it was learned.

2. **Catholic Hospital Association;** Ray Kneifl; $6500. For research in supervisory training for hospital personnel.

3. **Catholic Hospital Association;** Ray Kneifl; $3600. For development of hospital safety checklists.

4. **University of Arkansas;** Donald Stewart; $14,850. Nursing records project.

5. **State University of New York;** Dr. Herbert Notkin; $10,870. Study of the effects of teaching and research programs on hospital operating costs.

6. **American Hospital Association,** Maurice Norby; $71,480. Study of the operation of hospital planning and licensure laws.

7. **American Pharmaceutical Association;** Don Francke; $36,000. Study of hospital pharmacy services.

8. **Mississippi State College;** Marian T. Loftin, Ph.D.; $16,500. Hospital-community relations.

9. **Peter Bent Brigham Hospital,** Boston; Thomas M. Hill; $39,707. Management study.

10. **Ohio State University;** Daniel Howland; $60,912. Study to develop methods of evaluating patient care.

11. **American Psychiatric Association;** Dr. Charles Bush and Al Gutterson, $66,534. Study of mental hospitals.

Iowa Hospitals Will Appeal Court Ruling

Compliance not necessary while case is under appeal, attorney explains. Says court ruling would reduce hospital to "no more than a building"

DES MOINES.—At a general assembly meeting of the Iowa Hospital Association here last month, 61 hospital trustees, 19 hospital attorneys, 83 hospital administrators, and 38 other hospital representatives voted unanimously to appeal to the Iowa Supreme Court District Judge C. Edwin Moore's recent decision in the hospital-physician dispute.

A. A. Herrick and Herschel G. Langdon, trial attorneys for the hospital association, explained to the general assembly that the appeal will forestall any attempts to force compliance with Judge Moore's ruling, which held that Iowa hospitals employing physicians on salary and percentage arrangements are engaged in the illegal practice of medicine. Hospital representatives at the meeting voted unanimously to "maintain the status quo" until the supreme court reviews and rules on the case. Judge Herrick predicted that such an appeal might take a year.

In addition to being an attorney for the association, Judge A. A. Herrick is a member of the board of trustees of Iowa Methodist Hospital here. Judge Herrick presented the following comments on the district court judge's decision:

"Judge Moore states that he 'finds there has been no actual interference by the hospital trustees or administrators with the professional services of the pathologists and radiologists.'

"Judge Moore states: 'The court finds this dispute does not involve the quality of laboratory and x-ray services.' The record at the trial was clear and undisputed that laboratory and radiology service in Iowa hospitals is good.

"Judge Moore states: 'It is the conclusion of the court that under the facts established in this case and the law as the court understands it the work done by the pathologist, radiologist and the technicians working in the pathology and x-ray laboratories constitutes the practice of medicine.'

"Probably the most shocking declaration of the entire opinion is the statement by the court that *'the technicians working in the pathology and x-ray laboratories and the work they do constitutes the practice of medicine.'*

"The court states: 'The court is not to be understood as holding that the plaintiff hospitals cannot own and maintain the facilities of pathology and x-ray laboratories and receive just compensation for the use thereof.' This can only be interpreted to mean that hospitals can own and keep up the physical facilities and rent them to pathologists or radiologists.

A.H.A. HOLDS MEETING

Chicago.—Legal implications of the Iowa decision for other states were discussed at a special meeting called by the American Hospital Association here December 17. Attending were members of a special committee of the A.H.A. board of trustees and attorneys representing a number of state hospital associations. Attorneys at the meeting agreed the most damaging aspect of Judge Moore's decision, and the one most likely to be overruled on appeal, was the ruling that laboratory and x-ray technicians are engaged in the practice of medicine.

"Briefly, the opinion means that the hospital must surrender its laboratory and its x-ray department to the medical specialist. The hospital cannot employ the technicians, because under the court's ruling they practice medicine and this is something that a corporation may not do.

"The hospital cannot make a charge for laboratory or x-ray services or bill or collect for the same because that not alone involves the practice of medicine, but it also involves the matter of a division of a fee for something that has been defined as the practice of medicine.

"A hospital cannot determine the number or the compensation of technicians, and hospital trustees and administrators have no say as to what the amount of laboratory or x-ray fees is to be. That is the exclusive province of the medical specialists.

"In Iowa there are 176 nonprofit hospitals; 127 of these hospitals have no pathologists. Under the existing system the technicians in these hospitals forward tissue specimens for examination to Iowa City, Chicago, Omaha and Des Moines where they are examined by a pathologist and his report returned to the hospital which makes a charge for the same. This the hospital may no longer do. The pathologist in Chicago, Iowa City, Omaha or Des Moines must make the charge; he will also have to make some arrangement for employment of the technicians to prepare and forward the specimen. In connection with the routine laboratory tests, such as urinalysis, blood count, and other procedures ordinarily performed in these 127 hospitals, a hospital technician can no longer perform and charge for these

procedures. Either the nonresident pathologist or some other doctor will have to be found to employ the technicians and bill for these services.

"The situation will be similar in the 35 hospitals where there is a part-time or visiting pathologist who comes at intervals of once a week, or more frequently, and it will not vary greatly in the 14 hospitals which have full-time pathologists, except that the pathologist will be more easily accessible.

"A special problem is presented to the county hospital because our supreme court has held that county owned facilities cannot be leased. Some question has been raised as to whether county hospitals are affected by the court's findings. Judge Moore states: 'The plaintiffs other than the Iowa Hospital Association are all operated by nonpecuniary profit corporations, or in the case of county hospitals certain trustees . . . or in the case of municipal hospitals certain trustees. . . . For the purpose of this case the court finds it unnecessary to treat the three types of hospitals separately.'

"It is clear that the court intends to affect county hospitals. Hope for another interpretation may have been gained from the language of the findings wherein the court states: 'The court does not intend that any findings or conclusions herein affect in any way the obligation of public hospitals . . . as well as the state hospital at Iowa City to provide medical treatment for indigent persons or tuberculous patients. . . .'

TRYING TO MAKE AN EXCEPTION

"It is perfectly obvious that the court is trying to carve out an exception and hold that his findings and decision do not apply to indigent patients in county hospitals, municipal hospitals, or at Iowa City, where the pathologist and radiologist are employed on salary. In the first place, the hospital at Iowa City and the county hospitals, such as Broadlawns in Des Moines, where indigent patients are cared for, are authorized to and do care for paying patients. The law expressly provides that paying patients are entitled to such care in those hospitals. The court appears to try to carve out an exception on the basis that indigent patients do not pay a fee. There is nothing in the medical practice act which makes a violation of the practice act depend upon whether or not a fee is charged. In any event, so far as the county hospital is concerned, Judge Moore makes it clear that his decision applies to paying patients.

"Coming back to the matter of nonprofit hospitals leasing laboratories and x-ray departments, they are at once faced with the loss of tax exemption. The Code of Iowa, 1954, exempts from taxation grounds and buildings of charitable hospitals used solely for their appropriate objects and not leased or otherwise used with a view to pecuniary profit.

"If a court will go back to a statute passed in 1886 before laboratories and x-ray departments existed and apply a statute intended to eliminate quacks and charlatans from the medical profession to nonprofit hospitals whose sole object is to furnish care to the sick and injured at less than cost, such a court is going to find hospitals which lease out laboratories and x-ray departments are not using their property solely for their appropriate object and that such property cannot be classified as 'not leased or otherwise used with a view to pecuniary profit.'

"The rule, repeatedly stated in the cases relative to tax exemptions, is that the statute will be strictly construed in favor of taxation and against the exemption.

"In an informal opinion, the research department of the State Tax Commission has stated that the leasing of a laboratory or an x-ray department will result in the loss of the exemption.

"A further problem is presented in the matter of qualifying under the Hill-Burton Act for federal funds. A hospital must be nonprofit to qualify for such federal funds.

"Certainly, if laboratories and x-ray departments are leased to doctors who make a profit therefrom, part of the earnings inure or may lawfully inure to the benefit of an individual, namely, the doctor specialist involved.

"Certainly, if the hospitals are required to pay taxes it is going to mean higher patient cost and if the doctors are to control and fix the fees, it is certain that laboratory and x-ray fees are more likely to be higher than lower.

"Blue Cross and other commercial insurance companies, under the existing system, insure and pay laboratory and x-ray fees for services furnished by hospitals. These services will be impaired and disrupted if the charges are to be made by the doctors.

"If laboratories and x-ray departments must be turned over to the doctors and the charges made by them because of the x-ray and laboratory technicians practicing medicine, what answer can the hospital have to disprove that the nurse practices medicine, the technician who operates the EKG machine, the physical therapist, the dietitian, and the pharmacist who is licensed under the same code provision as the doctor?

"The hospital of the future is going to be no more than a building, a leasing corporation renting out concessions to doctors and specialists who perform the various functions that have heretofore been coordinated as a unit known as a hospital for the care of the sick and injured at less than cost and made possible by donations of the leading generous individuals of the community interested in the public welfare.

"As we see it, if the opinion of the attorney general and the court is to stand, it is the first step in the disintegration of the hospital as a complete and coordinated unit for health care."

AUTHORITIES CITED

"An examination of the authorities cited by Judge Moore includes such cases as State *v.* Huey, which involved a magnetic healer, the case of State *v.* Howard, which involved a defendant who claimed to practice naprapathy, and State *v.* Baker, which involved the so-called lay clinic for cancer cure. The court quotes from the Baker case as follows:

" 'Medical practice acts are enacted for the protection of the public against the unskilled treatment of the sick or diseased by persons having neither the preparation nor the skill to diagnose diseases or to administer powerful and poisonous drugs. The welfare of the public is of the utmost concern in the enforcement of the laws designed to guard and protect the public health.'

"We feel that it is entirely wrong to class a nonprofit hospital, caring for the sick and injured for less than cost, with the quack, the charlatan, and the incompetent.

"In Goldwater *v.* Citizens Casualty Co., the court quotes as follows: 'The general rule that a corporation may not practice medicine has its exception in charitable hospital corporations which are organized for that express purpose and are sanctioned by law to treat the sick and injured.'

"Judge Moore then states: 'If the

(*Continued on Page* 172)

The Modern Hospital
JANUARY 1956

A.M.A. MOVES TO PROTECT GP's

Accreditation Commission asked to rule against hospitals barring GP's; new committee will seek to upgrade nonsurgical services; hospitals told "organized medicine can solve its own problems"

BOSTON.—The American Medical Association last month dug in its heels to resist what A.M.A. members see as a trend toward specialist control of the practice of medicine in hospitals.

At one A.M.A. committee meeting during the annual clinical session here, 44 speakers appeared to express fears that the general practitioner—or generalist, as he now prefers to be called—is being pushed out of the hospital.

Unless the trend is reversed, the general practitioner will dwindle and die, like a flame without fuel, it is feared.

In a series of resolutions and reports approved by the house of delegates, the A.M.A. took these steps to provide new fuel for the general practice fire:

1. Instructed A.M.A. representatives on the Joint Commission on Accreditation of Hospitals to "stimulate action by that body leading to the warning, provisional accreditation or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class."

2. Established a Continuing Committee on Medical Practice consisting of five delegates, three of whom must be general practitioners, to "conduct a study of the relative value of diagnostic, medical and surgical services" and "present a program of public education designed to bring about a better understanding of all fields of medical practices"—maneuvers aimed at upgrading nonsurgical services.

3. Recommended that the A.M.A. Council on Medical Education and Hospitals "encourage hospital staff rules which permit the general practitioner staff member privileges in the specialty departments in keeping with his merit and demonstrated ability," and instructed A.M.A. representatives on the Accreditation Commission to "seek adoption of the above recommendation by that body."

4. Directed the new committee on medical practice to "utilize all possible means to stimulate the formation of a department of general practice in each medical school."

5. Avoided direct attack on the specialty boards but expressed "full accord" with a report suggesting "reappraisal of the practice restrictions" of specialty boards.

6. Asserted that "organized medicine is ready, willing and able to solve satisfactorily its own problems, and such assurance should be given the American Hospital Association or any other group concerning itself with such problems." This was a watered-down version of an earlier resolution requesting boards of trustees of hospitals "to refrain from demanding that medical

A.M.A. CHEERS IOWA

The following resolution was approved by the house of delegates of the American Medical Association during the annual clinical session at Boston:

"Whereas, the physicians of Iowa have for the past year been engaged in supporting the position that the practice of medicine is the right of the individual, and

"Whereas, a decision rendered by a district court of the state of Iowa upheld this position, and

"Whereas, this decision is expected to have a far-reaching effect upon the practice of medicine throughout the nation; therefore, be it

"Resolved, that the house of delegates of the American Medical Association congratulates the physicians of Iowa upon the successful outcome of the initial phase of this action, and commends them for the able way in which they presented the position of the American medical profession."

In presenting this resolution to the house of delegates for approval, the reference committee said: "The committee notes with gratification the decision of the judge in this case, which is in full support of the contentions of the physicians involved. Your committee recommends the adoption of this resolution, with expressions of appreciation to the many physicians of Iowa who have labored so industriously in support of the rights of our profession."

The reference committee report, including the resolution, was unanimously approved.

staff members submit to an audit of their books for the purpose of detecting fee splitting."

These moves to strengthen the position of general practitioners in hospitals, and in medicine generally, were seen as a sweeping victory for the American Academy of General Practice. Academy members were all over the place during the house of delegates meetings, introducing and speaking for resolutions and reports, sitting on reference committees, and taking part in the committee discussions. "The Academy got everything it wanted," one member said jubilantly as the final session of the house of delegates drew to a close.

When it wasn't busy building fences around the general practice of medicine, the house of delegates attended to some other serious business. Much of it, inevitably, was of interest to hospitals. For example:

Internship Essentials. In giving approval to the revised Essentials of an Approved Internship, delegates finally put the one-fourth rule for internships into operation. Hereafter, a hospital which for two successive years does not obtain one-fourth of its stated complement of interns may be disapproved for intern training. On recommendation of the Council on Medical Education and Hospitals, the delegates also voted to discontinue approving straight internships in obstetrics and gynecology after June 30, 1957. Straight internships in medicine, surgery, pediatrics and pathology were recognized as educationally sound and will be continued, on recommendation of the council.

Hospital Accreditation. Through its reference committees, the house of delegates considered several resolutions criticizing the Joint Commission on Accreditation of Hospitals. These resolutions were not acted upon but were referred to the special A.M.A. committee now studying Commission activities. The committee was formed following the last session of the house of delegates in June 1955 and will report back to the house at its June 1956 session in Chicago.

Practice of Pathology. Approving a resolution introduced by the Kentucky delegation, the house of delegates noted with alarm "attempts by certain lay groups to amend the laws, or their interpretations, to permit the division of pathology into professional and technical services, the latter to be the work of the pathologist's technical assistants who perform under his direction and supervision and not to be considered the practice of medicine and, therefore, services which may be legally performed by a hospital." Calling this "fragmentation of the practice of pathology," the house of delegates asserted its opposition to "division of any branch of medical practice into so-called technical and professional services."

Medical School Practice. As it did at its last session, the house side-stepped

GP and Surgeon Discuss Hospital Privileges on A.M.A. Panel and Agree: "No Easy Answer"

BOSTON.—A general practitioner and a surgeon agreed here last month that there is no easy answer to the difficult problem of assigning surgical privileges to members of the hospital staff.

In a panel discussion during the clinical session of the American Medical Association, Dr. John S. DeTar of Milan, Mich., president-elect of the American Academy of General Practice, acknowledged that general practitioners should be restricted to procedures for which they have adequate training and demonstrated competence.

Speaking for surgeons, Dr. Leland S. McKittrick of Boston, a member of the board of regents of the American College of Surgeons, admitted on his side that board certification leaves much to be desired as a method of judging surgical competence.

Beyond that point, the panel members disagreed as to the best method of extending surgical privileges in hospitals.

Individual competence as evaluated by the man's colleagues on his own hospital staff is the method preferred by Dr. DeTar, a general practitioner who, in his own words, doesn't do surgery because he wasn't trained in surgery.

According to Dr. McKittrick, imperfect as it is, board certification is still the best method of qualifying surgeons. Reluctantly, Dr. McKittrick said he had misgivings about trusting the judgment of hospital staff associates. The judgment of a man's associates may be affected by a number of factors other than professional competence, he pointed out. "A man would not be judged solely on the basis of his ability to render service to the community," he said. These other influences, he added, are not present in the judgment of specialty boards.

Earlier in the discussion, Dr. DeTar described conditions he said might lead to "extinction" of general practice, unless checked by A.M.A. action. These are:

1. Hospital restrictions on general practitioners.

2. Failure of medical schools to teach general practice.

3. Inadequate numbers of general practice residencies and general practice residents.

Dr. DeTar described letters coming to the offices of the American Academy of General Practice from people who want family doctors. "We want a general practitioner who will come when we want him and know what he's doing when he gets there," one of these said.

The pendulum has swung too far in the direction of specialization, Dr. DeTar said. Overemphasis on specialty practice has led to higher medical costs and could easily lead to government control of medical practice, since specialty groups are "more susceptible to regimentation" than general practitioners. He didn't say why.

SURGEON'S VIEW

In his presentation, Dr. McKittrick acknowledged that prolonged specialty training today required "tremendous financial sacrifice" on the part of young doctors in residency training, compared to doctors of the previous generation, but, he said, today's methods have led to great improvements in medical care.

Dr. McKittrick dissented strongly from the notion that in most cases the general practitioner performs the diagnosis and is responsible for preoperative and postoperative care, and "the surgeon just cuts."

"That's not our concept of a surgeon's function," he said. Instead, he explained, the young surgeon must be taught all about surgical diagnosis, preoperative and postoperative care, surgical physiology, anatomy and pathology, in addition to the technics of operative procedure and, most important of all, surgical judgment — the ability to correlate symptoms and pathological findings and judge when to intervene and just what to do.

Dr. Edwin L. Crosby, director of the American Hospital Association, was moderator for the panel discussion.

a request for action against "the practice of medicine by tax supported medical schools." The whole relationship of private practice and full-time clinical departments in medical schools is under study by the Council on Medical Education and Hospitals and the Council on Medical Service, it was explained. Hearings on the subject have been held, various legal problems are under review, and a symposium on medical education in relation to private practice has been scheduled at the annual congress on medical education and licensure in February. Noting these steps in progress, the house of delegates followed the recommendation of reference committees and took no action on the move to condemn tax supported medical schools as "socialized medicine."

Economic Policy. For the second time, the house of delegates looked the other way on a California proposal that the A.M.A. should create a far-flung Commission on Economic Policy with powers to investigate and inform doctors and others how to achieve an American economy with "a constantly increasing amount and variety of goods and services available to every individual living within our economy at a price that individual can afford to pay" —a goal which the delegates decided, understandably, that the A.M.A. had neither the authority nor the means to seek. In reaching its decision, the house of delegates reversed the recommendation of its Reference Committee on Insurance and Medical Service headed by California's Dr. Lewis A. Alesen, one of the originators of the Economic Commission idea.

Medical School Construction Grants. Following a parliamentary uproar during which the speaker of the house of delegates, the vice-speaker and a dozen or more delegates from Texas to Maine crisscrossed one another's tracks for half an hour, the house upheld A.M.A. policy in favor of one-time federal grants to medical schools for construction purposes only. The vote to uphold came at the end of a long discussion during which, at one point, a vote on a substitute motion that would have reversed A.M.A. policy failed when the speaker ruled a voice vote inconclusive and allowed the discussion to continue.

Social Security Amendments. In a departure from previous A.M.A. practice, the house of delegates recommended that state societies poll their memberships on the question of including physicians in old-age and survivors insurance provisions of the Social Security Act. There was no question, however, about where the A.M.A. stood on H.R. 7225, the bill to amend disability provisions of the Social Security Act. The amendments, said a resolution approved unanimously by the house of delegates, are "a typical example of an irresponsible political approach . . . in that this measure was conceived in secret in the committee on ways and

Can't Solve Problems by Sitting on Pedestals Waiting for Help, Says A.M.A. President-Elect

BOSTON.—Physicians must disprove the charge that organized medicine is "against every measure that would enhance the health and welfare of our citizens," Dr. Dwight S. Murray of Napa, Calif., president-elect of the American Medical Association, said at a public relations conference preceding the annual clinical session here.

"We have to get around the problem posed by the individual who says, 'My doctor is wonderful, but the others you can have,' " Dr. Murray declared.

"We talk much about how good medical public relations begins in the doctor's office. Unfortunately, that's where most of it also ends. Outside his own office many a doctor shields himself from contact with other citizens, like a cloistered nun. He uses his wife and children as a buffer between himself and his neighbors."

It is the responsibility of physicians, individually and collectively, to seek out and cooperate with other groups interested in the welfare of the community, Dr. Murray said.

"No one is going to give one hoot in Hades about the problems of the medical profession if we sit on our pedestals waiting for others to come to us," he warned.

Doctors often express the feeling that nobody understands them and their problems, the president-elect said.

"How can they?" he asked. "We never give other people a chance to know us. Do we understand our neighbors and the rest of the citizens of our communities? We know their appendices and their kidneys and their livers and their tonsils, but we don't know what makes them tick as fellow human beings who live and eat and work and play just as we do."

In an address to the opening session of the A.M.A. house of delegates, Dr. Elmer Hess of Erie, Pa., A.M.A. president, said that in all his public appearances as president of the association "there is one basic truth I've tried to drive home repeatedly—that doctors take care of sick folks, period."

Medicine can easily become a racket if other considerations are put ahead of the one simple, humanitarian service to which all doctors are pledged, Dr. Hess added.

"Before we can successfully achieve the objectives we proclaim to the public, we have to deal with some critical problems affecting internal relationships in the field of medicine," the president said.

"Uppermost is the situation existing between some of the hospitals and the anesthesiologist, radiologists and pathologists. I cannot go into detail on specific instances because there are peculiar local circumstances to be considered in each case. However, I have found that where serious differences of opinion exist between hospital administrators and specialists, stubbornness and lack of understanding create the roadblocks that cut off amicable solution.

"We don't want hospitals to engage in the practice of medicine, and we don't want them to exploit physicians, or the public, either. At the same time we must recognize the fact that departments of radiology, pathology and anesthesiology should be self-supporting."

Dr. Hess also referred to criticisms of the Joint Commission on Accreditation of Hospitals. "I am hopeful that the committee which has been appointed to review functions of the Joint Commission will come up with recommendations that will eliminate the points at issue," he said. "The citizens of this country, the hospitals and the medical profession owe much to the Joint Commission for the protective service which it has always rendered. We should be able to iron out any wrinkles which may exist.

"One of our greatest internal problems is a reluctance to recognize the fact that we are not cast from a perfect mold. A major responsibility which we have to the people we serve is to assure them of top quality medical care by men of unquestionable integrity."

means, adopted in brief executive session without public hearings despite the request of many witnesses to be heard, rushed to the floor of the House of Representatives before the report of the committee on ways and means was available, pressured through the House by a maneuver which by-passed the committee on rules, permitted no amendments and allowed only 40 minutes of debate." The resolution added that the proposed amendment constituted an invasion of the patient-physician relationship and threatened to "destroy the principle upon which our successful system of medical care has been built."

In opposing H.R. 7225, the A.M.A. urged instead the creation of a "well qualified commission, either governmental or private or both, to make a thorough, objective and impartial study of the economic, social and political impact of social security, both medical and otherwise, and that the facts developed by such a study should be the sole basis for objective, nonpolitical improvements to the Social Security Act, for the benefit of the American people."

Salk Vaccine. Writing what it hoped might be a final verse in the Salk vaccine saga, the house of delegates "heartily approved" a publicly expressed policy of the National Foundation for Infantile Paralysis to return to and maintain its original policy of devoting its funds to research and assistance in the care of patients, instead of purchasing and supplying vaccine. The delegates recommended that further purchase and distribution of Salk vaccine be carried out through presently available commercial avenues used for other immunizing agents and added the recommendation "that all vaccines, once proven, should enter the usual channels of distribution."

Principles of Medical Ethics. The house of delegates considered a proposal by the Council on Constitution and By-Laws to reorganize the Principles of Medical Ethics into a simplified system of medical ethics, on the one hand, and precepts of manners or etiquette, on the other. The proposals were referred to a joint session of the Council on Constitution and By-Laws and the Judicial Council, for further consideration by the house of delegates at the Chicago session next June.

Military Affairs and Civil Defense. In connection with national defense and medical military affairs, the house of delegates urged the board of trustees and Council on National Defense of the A.M.A. to cooperate with the Defense Department in strengthening incentives for military medical careers and maintaining liaison with physicians in the armed service. The house also recommended continuation of the council's survey of discharged medical personnel and assistance for discharged physicians, providing information on available positions in civilian life. However, the house of delegates turned down a Texas proposal for the A.M.A. to sponsor a court test of the legality of the doctor draft. Conceding that the draft is "discriminatory legislation disliked by legislators, government administrators and physicians in and out of uniform," the house nevertheless decided the Texas proposal would present "innumerable and complex legal and administrative problems for the A.M.A.," and that, actually, the legality of the law had already been tested in a previous decision.

ASK CIVIL DEFENSE AID

The house of delegates also urged that "all assistance should be provided" by the Federal Civil Defense Administrator to local communities in target areas to facilitate early distribution of the 200 bed improvised civil defense hospital, describing the improvised hospital as "an essential means of augmenting existing medical facilities during and after disaster."

Medical Care Plans. The house listened to a progress report by Dr. Leonard W. Larson, chairman of the Commission on Medical Care Plans, which is making a detailed study of all kinds of medical prepayment plans, and delegates discussed a resolution proposing that the A.M.A. participate in development of uniform minimum standards for voluntary health insurance plans sponsored by medical societies. Following discussion, however, the house accepted a reference committee recommendation that any such action should await completion of the commission study, and that formulation of minimum standards was appropriately a task for the plans themselves, and particularly the Blue Shield Commission, rather than the A.M.A. In an unusually cordial gesture toward Blue Shield, which has not always had the enthusiastic support of delegates, the house then approved two separate resolutions expressing appreciation for the efforts of Blue Shield plans and their participating and cooperating physicians.

Commission on Mental Illness. At its opening session, the house of delegates heard a report from Dr. Leo H. Bartemeier, chairman of the board of trustees of the new Joint Commission on Mental Illness and Health. With sponsorship by the A.M.A., American Psychiatric Association, American Hospital Association and other interested agencies, and with federal support totaling $1,250,000 over a three-year period under the Mental Health Study Act, the commission will undertake a nationwide study and reevaluation of the human and economic problems of mental illness, Dr. Bartemeier said. Headquarters of the commission will be established in Boston, he added. Dr. Jack R. Ewalt, commissioner of the Massachusetts Department of Mental Health, has been appointed director of the joint commission's study.

"The task facing the commission is gigantic," Dr. Bartemeier told A.M.A. delegates. "We feel, however, that with government and private money available, we now will be able to lead a new attack on the most alarming health problem facing the American people today."

General Practice Discussion. While delegates listened politely and interestedly to Dr. Bartemeier, it was plain they were more concerned about the plight of the general practitioner. Resolutions and reports having to do with the problems of general practice were referred to the Reference Committee on Insurance and Medical Service, which played to a packed house of 200 to 250 doctors, compared to groups of 75 or less attending the other committee meetings.

Most of the 44 speakers who appeared before the committee to talk on the subject were convinced that arbitrary restrictions imposed by hospitals and neglect of general practice in medical schools would ultimately result in the disappearance of the general practitioner, or his emergence as a "second class physician," unless the trend were reversed. "A man is a fool to try to be a general practitioner today," said a delegate from Ohio who described himself as a family doctor with 30 years of practice in the same small town.

Other speakers told lurid tales of restrictions imposed by hospitals, ranging from Dr. John S. DeTar's* classic case of the practitioner who wasn't

(*Continued on Page* 136)

* For Dr. DeTar's report of a survey of restrictions on general practitioners imposed by hospitals, as related by officers of various state chapters of the American Academy of General Practice, see page 91.

The Word for the Wives Is Discretion

Whether it is sharp or blunt,
the tongue is a deadly weapon with which
an unwise wife can cut the ground
right out from under her husband's career

JANE BARTON

A WAGGING tongue has tripped more than one hospital administrator right out of a good job, and in all too many cases the tongue was wagged by the administrator's wife.

The power of a woman either to push her husband up the road to success—or shove him over a cliff—is well recognized by industry. In a recent article in a national magazine it was pointed out that many firms engage in a quiet "wife inspection" before they hire a man for an executive position. They want to know as much about her as they can find out: "from how much she drinks to whether she overdresses or leaves dirty dishes in the sink."

That hospital boards should be at least as wary is the burden of the accompanying article (*p.* 54) by an administrator's wife. Mrs. Glenn M. Reno, an alumna of the "school for wives" conducted at the University of Minnesota's course in hospital administration, points out that the hospital administrator is even more vulnerable to criticism leveled at his wife than the businessman is. In the small communities, particularly, the administrator's family leads the kind of gold-fish bowl existence that ministers' families have long since come to accept. Unless the administrator's wife is profoundly aware of the demands of her husband's job and sensitive to atmosphere, she can place him in an untenable situation without being aware that she has erred until it is too late. And some of them never do suspect themselves of being at fault.

HOW THE IDEA GREW

It was the growing realization by James A. Hamilton, the course director, that too many administrators' wives lack this necessary understanding and sensitivity that led to the establishment of a school for wives. In attempting to analyze the reasons some young (and some not so young) administrators failed in jobs for which they were apparently well qualified, Mr. Hamilton and his associate, James W. Stephan, came to the conclusion that in several specific instances the failure could be traced to the administrator's wife: She talked too much; she interfered; she was gauche in her relations with her husband's associates; she disliked her surroundings and let her dislike be known. There was a variety of causes and most of them, Mr. Hamilton and Mr. Stephan agreed, stemmed from sheer ignorance of what an administrator's job really is and the demands it makes upon the wife. The solution seemed to be to educate the wife along with the husband. And so the Minnesota course came into being. There are now similar courses at certain other universities that train hospital administrators.

There was no precedent for the Minnesota course, as far as anybody knew, so it had to be worked out on a trial-and-error basis. Furthermore, it seemed to Mr. Hamilton and Mr. Stephan that the person best fitted to impart an understanding of the rôle played by an administrator's wife obviously would be—an administrator's wife. It should be a person who had herself encountered, perhaps on occasion fallen into, the pitfalls that beset the young woman and had learned from experience what to do and what not to do in all kinds of situations. Hopefully, they suggested to Mrs. Hamilton that she take on the task of organizing the course. Since she prefers to stay out of the limelight, Mrs. Hamilton's prompt acceptance of the job came as a happy surprise. She felt strongly that such a course could be invaluable and she was willing to tackle it, with one stipulation —she would have to have help.

Help was promptly forthcoming. Mrs. Stephan, Mrs. Ray M. Amberg and Mrs. Russell C. Nye serve with Mrs. Hamilton as counselors and preceptors. Although they do not give formal lectures, they act as hostesses at the meetings and, at the end of the school year, constitute a panel at a question-box session at which the wives ask all the questions that have been haunting them. To the students' wives, most of them strangers to the city, young and somewhat apprehensive of the future, the "faculty" is an endless and deeply appreciated source of comfort and guidance.

The first sessions were extremely

informal, and they still are, but over the years the course has settled into a definite pattern (described in Mrs. Reno's article) to meet the needs of the wives. The guest lecturers enjoy the sessions as much as the students do and look forward to coming back each year.

In an effort to determine not only how the course has helped the Minnesota group, but how important it is to the wife of any administrator (young, old or middle aged) to be given an insight into her husband's job, The MODERN HOSPITAL interviewed several of the wives and sent out some 160 questionnaires to alumnae in all parts of the country. The answers gathered in the interviews and received from approximately 50 respondents to the questionnaire indicate that (1) the course has tremendous value in preparing the wives to do a good job in their supporting rôle, and (2) there is no doubt in the minds of these women as to their importance in their husbands' careers.

Asked what they considered the most valuable feature of the course, the majority agreed that the advice and suggestions concerning the social aspects of hospital life, plus the op-

WHEN THE BOARD TAKES AN ADMINISTRATOR IT HAS TO TAKE HIS WIFE

ERMA RENO

IN THE old nursery jingle "Farmer in the Dell," you remember, the farmer took a wife, the wife took a child, and then the endless chain of events began. The words, the board took an administrator, the administrator took (or had) a wife, could easily be substituted for the first two lines in this familiar song. Perhaps the board member will say, "I didn't take a wife—I just hired the husband." Perhaps, too, the wife element in the success of a hospital administrator's career is not important but, before jumping to such a conclusion, let's give the wife's rôle a little thought.

The hospital is a community project and as such is a frequent topic of conversation among the groups of women volunteers who work there, as well as in the more social groups whose friends, families and acquaintances go to the hospital for treatment. The hospital administrator's wife is also a member of the community. Even though she takes no part in actual hospital matters she has many contacts with those who do—the butcher, the P.T.A. members, her church friends, her neighbors.

Just imagine what complications might result from the wrong answer, a defensive or argumentative answer, or *any* answer, sometimes, to such typical comments as the following from well meaning but uninformed members of the community, especially in small communities where quotes and misquotes have a way of traveling fast and gathering momentum in their travels:

"Why doesn't your husband fire that incompetent nurse who cared for my little boy following his T.A.?"

"The very idea of visiting hours—why can't the family go in at all hours?"

"I was really insulted when that hospital required a deposit in advance. Hmph!"

Mrs. Reno is the wife of Glenn Reno, director of Children's Hospital, San Francisco.

Also, it is surprising how much administrative disturbance can be caused if the administrator's wife has friction with the wife of the chief surgeon or with the dietitian, or if she adjusts poorly to the conventions of the local community.

At the University of Minnesota the faculty in the course in hospital administration became increasingly aware of situations which placed uninformed and unsuspecting hospital administrators' wives in embarrassing positions. Nine years ago, as an experiment, an informal organization of the wives of the students in hospital administration was set up. It met with such enthusiastic response that it has been continued every year and put on a more formal basis.

The informal course is designed to familiarize the wives with the hospital and with the working life of a hospital administrator. The wives are free, through an elected committee, to plan their own yearly program after polling the members as to things about which they wish to know more. Six meetings have been duplicated almost every year. One is a down-to-earth and inspiring talk by the course director, James A. Hamilton, in which he challenges the wives to be understanding of the complicated and time consuming problems confronting their husbands in the course of providing services for the care of the sick.

In another informal evening the associate director, James W. Stephan, explains different types and sizes of hospital organizations. All go away knowing a little more what to expect the day the husband comes home to announce excitedly: "I've just been offered a position in a 200 bed general hospital." Dr. Gaylord Anderson, director of the school of public health, spends another evening discussing the rôle hospitals play in the ever-widening field of public health and in tracing the history of hospitals in this country. At another meeting Dr. Stewart C. Thompson discusses basic medical terminology and brings the wives up to date on medical and hospital history. The last meeting of the year is the "Question Box" where the wives submit questions about anything and everything, from how to entertain the wife of the president of the board in a small apartment to should you work in the same hospital where your husband is serving his residency.

A highlight of the program is a conducted tour through Northwestern Hospital in Minneapolis, preceded by a luncheon at the home of the administrator, Russell C. Nye. The makeup of the wives' group is always diversified—nurses, teachers, students, mothers, secretaries. Many, surprisingly, have not been in a hospital since childhood, and then never into many of the behind-the-scenes departments. This tour gives the wives an understanding of many of the departments whose heads they will meet when their husbands become administrators.

Besides its educational value, the wives' course is fun. Some meetings are strictly social—get acquainted evenings, bridge, knitting, potlucks, which almost always result in recipe exchanges. Coffee and cookies are served at each meeting with the girls taking turns at serving and dishwashing. Later reunions at regional get-togethers after graduation are equally as exciting and pleasurable as those meetings planned for and attended by the husbands.

The wives don't leave the course at Minnesota feeling that they know all the answers or that they can meet any community situation. But they do leave feeling that when the board takes their husband it will also take a wife with a knowledge of and a tolerance for the many problems their administrator husbands will face.

Since this article was written, a lecture on the place and function of women's auxiliaries given by Mrs. Simon Meshbesher of the Mount Sinai Hospital Auxiliary, Minneapolis, has been added to the course. —ED.

portunity of getting acquainted and exchanging views with other students' wives, had been most helpful. They had a sense of "belonging."

Equally valuable, most of the wives reported, was Mr. Hamilton's pungent introduction to the hospital field —the orientation lecture that opens each year's course. In it he explains the complex human relationships with which a hospital administrator must deal and the emotional strain of the job, and he tries to engender an awareness of "why an administrator gets the way he does about the things he does."

By way of illustrating the horrors an unwise, unwary or selfish wife can inflict upon her husband, Mr. Hamilton cites such examples as Mrs. A., who loves to show off her knowledge of hospital affairs by gossiping about patients and personnel; Mrs. B., who hates small towns and says so to any small-town resident within earshot; Mrs. C., who won't let her husband take a job more than a hundred miles from home because she can't bear to leave Mamma, or Mrs. D., who makes a point of denouncing the favorite charity of the board president's wife.

Mr. Hamilton's grisly little stories leave many of the wives wide-eyed and a little scared, but they get the point across. His purpose—indeed, the whole purpose of the course—is not to "give all the answers" but to make the young women tolerant and understanding of the needs and feelings of others as an aid in adjusting to any situation in which they find themselves in later years.

How well that purpose is being accomplished is attested to by the answers to the questionnaire. Graduates of the Minnesota course for wives, it will be apparent, have a firm grasp on the dictum: "It is better to keep the mouth shut and appear dumb than to open it and remove all doubt."

The following answer to a question regarding ways in which participation in the course had helped the wives in getting along with trustees, medical staff, and employes summarizes the ideas expressed by nearly all respondents:

"Getting along with trustees and their wives: Always remember to be your natural self and no matter what you know about hospital affairs *do not discuss them.* If your husband comes home and blows off steam to you about his work or the people he has to work with, do not discuss it with ANYONE. It is just between you and your husband. He does need an outlet and his wife is his only backboard to bat away with." [Another respondent phrased this even more succinctly: "The wife should be a sounding board—without an echo."]

"Be pleasant with trustees and their wives and lead them to believe your husband is happy in his work and that you are happy in your surroundings, no matter where you are or what you have to put up with. Complainers are never respected. Do not try or expect to be taken in as a close friend. You're better off to keep the relationship casual.

"Dealing with personnel and medical staff and wives of staff members: Try to connect names with faces and remember them. Be cordial and

QUESTIONS ASKED MOST FREQUENTLY BY WIVES:

1. Do we have any obligations to entertain?
   As administrative residents?
   As assistant administrators?
   As administrators?
2. What are the different "types" of entertaining?
   What number of people are best accommodated by each?
   How does one organize the different types?
3. Should a wife work in her husband's hospital:
   In a paid job?
   As a volunteer?
4. How much income can we expect to have in the next two or three years?
5. If you are new to a community and have just been entertained by a "superior," which is better, a note or a telephone call to your hostess?
6. Is there an organization for wives of hospital administrators?
7. Are memberships in hospital guilds by invitation?
8. Are there any other organizations working in the interest of the hospitals that we would be especially interested in as wives of hospital administrators?
9. What is the purpose of a hospital auxiliary?
   Is the wife of an administrator expected to join the auxiliary? Should she assume any administrative office of the auxiliary?
10. Should wife attend all social activities at hospital to which she is invited? Are invitations a matter of form or do they really want you? Are they numerous?
11. To what extent is it wise for husband and wife to make an effort to know and entertain people associated with other hospitals in same community?
12. Should the wife of hospital administrator and family use auxiliary services of hospital, such as library or recreational facilities?
13. Is it wise for wife of administrator to use hospital employes or students as baby sitters or for any other part-time employment?
14. If it is necessary for the wife to work, should she work in same hospital as husband? In any other hospital in community? In any organization in which a board member is associated?
15. If financially able, is it wise for a wife to go to as many conventions as possible in order to meet people in field? What functions at a convention include wives?
16. May the wife of an administrator purchase supplies through the hospital?
    If you live on hospital grounds?
    If you live in community?

friendly but don't be too close. Never discuss hospital affairs with them or let it be known that you know anything about what is being discussed. If other wives want to talk, just be a good listener. My husband's respect for some of his employes faded when he found that their wives were too free with information. Be cordial to the medical staff and their wives but do not feel slighted or hurt if you're not taken into their social circle. It's better if you're not.

"If you have occasion to be in the hospital, be friendly to all employes, even down to the janitor. You may not know them, but they know you. You will find they all want to give you the best of service but don't demand any extra service just because of your husband's position. . . . Remember them the next time you see them and you have done a great thing for the spirit of the organization. Make it a point to be at all organization functions (picnics and parties) and make yourself just another one of the guests."

Learning how, when and whom to entertain apparently is a problem to many of the wives, and this problem is dealt with at length by Mrs. Hamilton and her fellow faculty members. Their advice—to be natural and informal and to make no effort to "keep up with the Joneses"—has been gratefully received by their students. Several made reports similar to this one: "Seeing how hospital administrators' wives planned and entertained has helped me on many occasions. Have even used some of the menus and recipes collected and/or sampled at the various meetings. I remember especially the advice to 'be yourself' and entertain within our own means and not try to match the trustees' station."

Two questions—"In what ways can the administrator's wife be most helpful to her husband?" and "In what ways can she be the greatest handicap to his career?"—elicited almost identical answers from all those who were interviewed or who answered the questionnaire:

The administrator's wife can be most helpful by:

"Being understanding of the complex problems he confronts during the workday."

"Being interested but not inquisitive."

"Being cordial to all his business associates and ready to greet them at home or at social affairs with cordiality and friendliness but at the same time maintaining a reserve and ignorance of hospital problems."

CAN BE A LISTENING POST

One woman elaborated on this theme somewhat: "The administrator's wife can be a valuable listening post or sounding board and report what she hears to her husband, but she must stay out of discussions with the girls involving controversial hospital issues. But she should be prepared to set straight those people in every community who bandy about grossly stupid and wrong information about the hospital, *provided she is not violating any ethical principle in so doing.* She can, if she is cagey and discreet, do a public relations job for her husband in the community."

Another said simply: "I feel an administrator's wife should be, first and last, a wife and mother, leaving the hospital's administration to her husband. Making his home a place in which he can relax and gain strength can be her most helpful contribution."

The reverse question, "How can a wife handicap her husband?" elicited these answers:

"Talking out of turn or indiscreetly on hospital subjects."

"Being too friendly with any segment of the hospital family, medical staff or trustees *or* being too distant."

"By being too brash and opinionated."

"By getting too involved in hospital affairs and adding many awkward situations to her husband's already complex job."

"By demanding too much of his time and attention."

"By being a busybody."

"By gossiping about hospital affairs."

"By criticizing or expressing dissatisfaction with the community."

"By being a social climber."

"By being discourteous to employes or to people in the community."

In regard to that last observation, more than one respondent warned that "the administrator's wife must remember to conduct herself properly even in a shopping crowd lest someone she doesn't see recognize her. It *has* happened to me."

The inability or unwillingness to adjust to the community is recognized by the Minnesota wives as a serious handicap. One of them went into this subject in some detail, as follows:

"If you don't like your surroundings, don't become a complainer. Your husband may not like them either but he has a job to do and you are supposed to help him, not hinder him. I once saw this in one of my husband's employes. His wife was a spoiled, helpless creature. She had been uprooted from the section of the country where she had always lived. We were in a small town and

Fourteen members of the school for wives, University of Minnesota course in hospital administration, gather in the living room of the Hamilton home for Mr. Hamilton's orientation lecture at the beginning of the season.

The faculty, left to right: Mrs. Russell C. Nye, Mrs. James A. Hamilton, Mrs. Ray M. Amberg, Mrs. James W. Stephan.

Student committee, l. to r.: Mrs. Lloyd Detwiller, Mrs. E. E. Gilbertson, Mrs. Edward R. Lynn, Mrs. Harold Weed.

she was very outspoken as to how she hated the town—even to lifelong residents, who were pretty proud of their town. She was a constant complainer and depended upon her husband at home for help to the extent that he could not do his work adequately. Eventually he moved on before he was ready financially or jobwise—just to please her. Because of her attitude, the community did not respect her husband as it might have if she had done her share."

Asked what advice they had to offer other administrators' wives, a large number of the respondents modestly contended that they were still in the position of seeking advice rather than giving it. However, many of them offered some sage comments that could be followed with profit by wives of all ages and degrees of experience:

"Be a good wife first. You married your husband, not his job. Be with him at hospital affairs when he wants you there; stay home when he doesn't."

"Be warmly friendly but not 'clubby' friendly. Be too busy the first six months in a new situation settling your family to make close or binding friendships which might prove unwise or unsuitable and be difficult to extricate yourself from. Case the town and its people well first. Choosing your friends slowly and deliberately may result in some lonely days at first in a strange community but probably will prove wiser in the end."

"Do not hinder your husband's chances of furthering his career by being unwilling to move to a new location. If you do move and you are unhappy in your new environment, try to make the best of it. You probably won't have to stay there forever and your husband's next opportunity may make up for any past unhappiness."

WATCH THOSE WOMEN

"In some hospitals your husband will be greatly outnumbered by women employes and some of them will take any man available! When at social functions, if one of these women gets hold of him, have faith in your husband; realize that he is cornered and not really enjoying it and that he isn't just neglecting you."

"Separate the family's social life as much as possible from the husband's business life."

"Be prepared for long and irregular hours, especially following a new appointment, and be adjustable to moving frequently. Be interested in your husband's work so that you may share his pride and joy (as well as his labors) in the work in which he finds happiness."

"Never become involved in hospital politics."

"Even when your husband tells you about the hospital, pretend you don't know anything about it."

"One eminent man in the hospital field once said, 'Keep your mouth shut!' This is the best piece of advice I ever had."

Even with the best intentions in the world, and with what one woman described as "the advantages of being a Minnesota wife," a wife will make a faux pas now and then. To find out what kind of traps people are most likely to fall into, the question was asked: "Since your husband has been on the job, what have you done that you wish you hadn't?"

One of the wives, interviewed on this question, grinned and replied with engaging candor: "I drank too much. I don't make a habit of it, but, you know how it is—the party just got rolling and so did we. Actually, I didn't say anything I shouldn't have, but I easily could have. And I was scared to death afterward. I'll never do that again."

Most of the replies concerned the old problem of talking too much, for example:

"I once, in a burst of friendly cameraderie, confided a bit of information to a doctor's wife and lost several nights' sleep afterward. Fortunately, she respected my confidence and I was lucky, but it taught me a good lesson. I haven't done it again."

Another wife wasn't so lucky:

"Gossip is a terrible thing. I mistakenly confided to a woman who, in turn, spread news which got back to the administrator — my husband's boss."

Other replies to this question included "getting mad" at the husband; being un-understanding of the demands made on his time, and taking too active a part in auxiliary work in spite of warnings from the lecturer on women's auxiliaries that the administrator's wife should be "interested but not involved."

Some respondents reported that, thus far, they had made no slips, but —"Just give me time!"

An interesting reverse switch on this question was offered by the wife

(*Continued on Page* 138)

Voluntary Hospitals Get Ford Grants

Hospitals to have large discretionary powers in determining how funds will be used, foundation official explains. One-half of grant to be paid right away, balance within 18 months—total $200 million

CHICAGO. — In the largest gift that has been recorded since the wise men took their gold, frankincense and myrrh to Bethlehem, the Ford Foundation last month gave away $500 million.

Nearly half the money was to be distributed to the nation's voluntary nonprofit hospitals—all of them—according to a formula based on patient days of care and births.

As the formula worked out, most hospitals would receive from $300 to $500 a bed. The maximum amount granted any hospital was $250,000, and the minimum amount was $10,000.

The patient day-birth formula was selected as the best reflection of the extent to which a hospital is used, a foundation announcement said.

Similar grants were made to every private, regionally accredited four-year college or university in the country, and to the nation's medical schools.

ADMINISTRATORS' QUESTIONS

After they finished holding their notification telegrams from the foundation up to the light to see if there were any tricks or hidden clauses, hospital administrators last month were asking three questions:

1. How can we use the money?
2. When will it be paid?
3. How did it happen?

The first two questions were partially answered in the foundation's initial announcement, and hospital recipients were to get a letter "shortly," according to the notification telegrams, explaining the details.

Briefly, the announcement said hospital grants would be approved as soon as each hospital presented evidence of tax exemption and reported preliminary plans for use of the money.

Within 10 days to two weeks following the announcement on December 12, the foundation expected to send explanatory letters and grant applications to every voluntary nonprofit hospital listed by the American Hospital Association, Quigg Newton, vice president of the Ford Foundation, told The MODERN HOSPITAL.

As soon as each hospital's application is received and processed, one-half the grant will be paid, he said. The remainder is to be paid at a date to be determined by the foundation, but not more than 18 months hence, he added.

Hospital grants may be used to improve and extend services to the community but not for operating expenses or to pay deficits, it was indicated. Either principal or income may be used for "improvement of or addition to facilities or services; additions to or training of personnel or conducting research," the foundation said.

"Several hundred thousand additional general hospital beds are needed," the foundation stated. "Old or obsolete buildings require replacement or modernization. Many hospitals need better equipment. All hospitals need to extend the scope of their services if they are to serve satisfactorily as health and rehabilitation centers in their communities.

"The pressing need is for funds to expand or modernize present facilities and extend service to keep pace with the rapid development of medical science.

"Use of the funds will be permitted for any program of improvement or extension of hospital service, but not for operating expenses for services currently being performed by the hospitals. A particular purpose of the grants would be to assist hospitals desiring to do so to achieve full accreditation with the Joint Commission on Accreditation of Hospitals."

The foundation suggested that specific uses might include new programs of disaster planning, mental illness, prematurity, rehabilitation, handicapped children, preventive or diagnostic services, outpatient care, or any other area which in the opinion of the hospital's board would best serve its community.

LARGE DISCRETIONARY POWERS

Hospital trustees will be given large discretionary powers in determining what other projects might fall within the terms of the grant, Mr. Newton explained. In making their applications, trustees will be asked to certify that the money is to be used in accordance with the foundation's requirements.

Individual questions about projects may be referred to the foundation for determination if necessary, Mr. Newton said.

Within the stated restrictions, hospitals could use the gifts as they saw fit, spending all the money for a single improvement if they wished.

"Hospitals have an immense responsibility to translate this gift into maximum benefits for the people of our nation," said Ray E. Brown, president of the American Hospital Association. "We applaud the emphasis on local determination of the method to be used. This flexibility will permit hospital trustees to take full advantage of their intimate knowledge of their communities and their needs."

An advisory committee which developed the plan for the grants in cooperation with the foundation's board of trustees said the broadside method of including all hospitals listed by the American Hospital Asso-

(*Continued on Page* 164)

Short of Nurses? Write to Your Congressman

A lawyer-trustee urges administrators to stop talking to themselves about the shortage of nurses and start talking where it will do them some good—to Congress

SAMUEL HORWITZ

PROVIDENCE has been good to me. I have never been away from my law office a single day on account of illness. I have had no personal experience in the health care field. When I was asked to serve as trustee of a large general hospital, I accepted it on the condition that I would not remain unless I could be helpful.

I took the job seriously. It never occurred to me that a trustee was simply supposed to show up at meetings, get his name in the papers, claim ignorance of medical and technical matters, and wash his hands of responsibility, leaving the hospital administrator holding the bag. In my naïvete I assumed that it was the duty of a trustee to study, understand, investigate and make recommendations with respect to the administration of the hospital. This I undertook to do—with resultant discomfort both to myself and to others. I have not been an "orthodox" trustee. Instead I have got myself involved so deeply in the whole field of medical care that it now threatens to become a major interest.

WHY CAN'T THEY GET NURSES?

It started very innocently. Here was I, a green trustee attending my first trustees' meeting. In the course of the discussion it came out that in spite of the fact that the hospital had many urgent cases waiting to be received, it had beds it wasn't using. "Why not?" I asked. The answer was, "We can't get enough nurses to take care of the beds." Again I said, "Why not?" and the answer was: "We can't get enough nurses because a sufficient number does not exist; and if we try to induce them to come to us by more pay, other hospitals will do likewise and *all* the competing hospitals will go deeper into deficits. On the other hand, women are not attracted to the nursing field because of dollar motivations but for other reasons; thus, increasing the pay will only increase the hospitals' annual deficits."

That hit me right between the eyes. For it turned out that our deficit wasn't temporary. It was annual! It was permanent! The institution *always* operated at a deficit, which had to be made up by the contributions of philanthropic individuals.

All my life I'd been associated with managers of enterprises operating at a profit. They thought they had their troubles. But imagine running an institution that knew, every year, year after year, it was going to wind up in the red! It would drive most men crazy. I took off my hat to the hospital administrators who have succeeded in doing a job that most businessmen would call impossible.

Naturally when you're operating on a deficit basis you can't do things as you would if you were operating on a profit basis. So—the hospital couldn't get enough nurses because it couldn't pay them enough.

Well, I thought to myself, is this peculiar to *our* hospital? How about other institutions and other fields that need nurses? When I looked into the matter I found that as far as the country as a whole was concerned, there simply were not enough nurses to go around. There was an urgent need for more. Not enough girls were going into the nursing profession. The over-all number was increasing, but not in proportion to the country's needs.

IT'S A PECULIAR SITUATION

This situation struck me as rather appalling and, from one standpoint, most peculiar. When there is a public demand for almost any product under the sun wanted by the American people, whether it is necessary, unnecessary or ridiculous, it is immediately supplied by private competitive industry. Thus we have at hand all the bubble gum we want, all the television we want, all the beer we want—but when it comes to nursing, which is a matter of vital importance for the welfare of the people, we run short. Why? The only answer I could come up with was that whereas the bubble gum industry, for example, flourishes under the system of private enterprise for profit, the nursing profession has grown up under the aegis of the nonprofit, tax exempt, deficit financing system under which most of our hospitals operate today.

The picture got more puzzling the longer I looked at it. As things stand now, the doctors collect, from hospital patients, fees that keep the doctors well in the black; but the hospitals go in the red and have to ask for charity to help them out. Wouldn't it be just as sensible for the hospitals to operate at a profit, and have the doctors do business on a deficit basis and ask for public contributions to help *them* out? I'm not suggesting any such thing—I'm just pointing it out,

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as a matter of logic. We're set up under the present system, and that's no doubt the way it's going to continue. But *how are we going to get the nurses we need?*

The deeper I dug, the more I became convinced that our present inability to fulfill the nursing requirements of the nation stemmed from the difference in the economic motivation of the three groups concerned, *i.e.* the hospital administrators, the doctors, and the nurses themselves.

NURSES ARE IN THE MIDDLE

The doctors, who have plenty of charity cases, and who are dedicated to public service, nevertheless run their affairs on a basis of making money. A hospital is a semipublic, tax free, charitable institution operating not with the purpose or expectation of making money but with the expectation of a deficit. The nurses are a professional group on salaries. They are employes. They are concerned with wage levels. And who are their bosses? The hospital administrators and the doctors. In short, they are sitting in the middle between two groups operating upon exactly opposite economic assumptions.

Furthermore, involved in this whole situation are the duties which the hospital administrator expects the nurses to perform, those which the doctor expects the nurse to perform, and the nurse's own concept of her own profession. These in many cases do not jibe. There is certainly need for clarification as to the duties of the nurse.

The more I puzzled over the whole picture, the more I realized that it was far too complicated for me as an individual to attempt to arrive at a solution. My immediate concern was the shortage of nurses in my own hospital, but the corrective answer involved so many problems that I felt it beyond me to tackle them under my own steam.

That was why, when I learned of the bill introduced into the House of Representatives by Congresswoman Frances P. Bolton of Ohio for the establishment of a National Commission on Nursing Services, I eagerly welcomed the idea and became chairman of a committee in support of the enactment of this bill.

I found that Mrs. Bolton had been far ahead of me. She had been interested in nursing problems all her life. For years she had been concerned about the urgent need for more nurses; and in an effort to learn the reasons for the shortage and the answers as to how it might be overcome, she had sent a questionnaire to some 10,000 representative nurses and nurses' associations, hospital administrators, nursing schools, doctors, laymen, state governors, educators, federal and state authorities and others, to which more than 4000 replied.

The replies can be summed up in just two sentences:

Everbody agreed that there was an urgent need *for more nurses.*

But there *was absolutely no agreement,* within or among the related professional groups, as to what should be done about it.

Most of the respondents to the questionnaire said that nurses' pay was too low and that opportunities in industrial and business fields proved more attractive. Some people cited state regulatory laws as presenting further difficulties. Some blamed restrictions imposed by the nurses' board; some said the nursing schools were not doing the proper job. The only over-all answer that emerged was that there were not enough nurses in the country and something would have to be done about it.

Mrs. Bolton's questionnaire went into the subject of nursing education, and on this subject there was no agreement either. Some people said that hospitals should not be permitted to operate schools of nursing, and others said that we need more hospital training courses; some said that we need more practical nurses' education which should be handled in junior colleges and vocational schools, and others said that we need better teaching in colleges and universities offering graduate nursing programs. Some people said that government should have no part in teaching nurses and others said that government should assume the responsibility for it. Some people said that nursing should be taught in high schools and others said it shouldn't.

Titles III and IV of the current Administration's bill sponsored by the Department of Health, Education and Welfare provide for direct federal aid for nursing education. Mrs. Bolton's questionnaire asked for opinions on this subject. She herself is supporting the Administration's proposals because she feels that immediate remedial steps are imperative. The people who replied to her questionnaire certainly had divergent opinions on this subject. They could not agree as to whether financial aid should be administered on the local or national level; whether it should be directed chiefly toward better courses for skilled professional nurses or shorter courses for practical nurses; whether it should go to schools, or directly to the students.

In short, what Mrs. Bolton learned from her questionnaire was just about what I learned as a result of being a trustee of a hospital, namely, that the entire picture was too complicated to be solved by any methods thus far undertaken, or by recommendations made by an individual or by groups in the nursing, hospital administration, or medical profession.

In view of the difference in the operating economics of these three groups —doctors operating at a profit, hospitals operating at a deficit, and nurses operating on a salary—it seemed obvious that it would require an outside agency, representing what Mrs. Bolton terms "the public patient and the patient public," to reconcile the points of view of these groups and to point the way toward a solution of the nursing dilemma which might be acceptable to all three.

CONGRESS IS IMPARTIAL

It is Mrs. Bolton's idea that the Congress of the United States might well serve as this outside agency. The Congress is an impartial body devoted to the welfare of the public at large. Representatives of the Congress, in discussions with representatives of hospital administrators, nurses and doctors, would not be hampered by the inability of these groups to view the picture except through the focus of their respective glasses. Therefore Mrs. Bolton has recommended a commission, set up along the lines of the Hoover Commission, to study the entire picture in relationship to the shortage of nurses, make findings of fact, issue recommendations, and suggest possible legislation.

I believed that with a commission such as Mrs. Bolton suggested, we might get somewhere. So when she asked me to be chairman of a committee in its support, I was only too eager to accept.

Now let me explain to you just what Mrs. Bolton's commission would be and what it would do.

Mrs. Bolton's bill provides for a commission to be composed of 12 members as follows:

1. Four appointed by the President of the United States—two from the executive branch of the government and two from private life.

2. Four appointed by the president of the Senate—two from the Senate and two from private life.

3. Four appointed by the speaker of the House of Representatives—two from the House of Representatives and two from private life.

Among the six members appointed from private life should be representatives of the hospital administration, nursing and medical professions.

Provisions for members from the executive branch of the government allow for adequate participation by the Department of Health, Education and Welfare.

The four senators and congressmen on the commission would be, you might say, the representatives of the patient—that is, the man who gets sick and has to go to a hospital.

The commission may hold hearings, employ the services of experts in its field of investigation, and obtain any facts it desires from governmental departments and agencies. It shall be granted a budget sufficient for its operations.

It may submit interim reports to Congress, and not later than two years from the time of its appointment it shall give Congress its final report, which will contain its analysis of the reasons for the growing demand for nurses and its recommendations as to what steps might best be taken to meet this demand.

COMMISSION POINTS THE WAY

Note that the commission merely gathers facts, makes recommendations and may suggest legislation—but does not control anybody or exercise any authority. It merely endeavors to point the way; and certainly it is high time that this be done by somebody. The nurses, the hospital administrators, the doctors and public authorities have been concerning themselves with the nursing situation for years, and advocating this or that, but what has been the result? *A shortage of nurses which today threatens to grow worse.*

In my opinion, one of the strongest reasons for the formation of a commission is the presence on the commission of congressmen and senators who will represent an outside point of view on behalf of the public welfare.

Well, you may ask, just what in particular should the commission study?

Let's assume that the commission undertakes its project on the basis of trying to find out why nurses are in short supply today, and why the situation threatens to become even more acute tomorrow.

The commission might start out with the problem of nursing education. Who should pay for it—the nurse herself, the patient, the hospital, the doctor, or the taxpayers?

How about governmental aid? Should there be continuing direct federal grants to nurses and to nursing education, such as are proposed in Titles III and IV of the Administration's pending bill which Mrs. Bolton is supporting? Should financial aid be set up on the basis of state matching funds? What type of financial aid will be most instrumental in persuading more young women to go into the profession of nursing?

How about the utilization of existing nursing personnel? Some believe the nurses should be confined to what they call the professional aspects of their education and leave other duties to others. Still others believe that nurses should be able to follow every kind of procedure accompanying the patient, even to the providing of linens, food and record keeping. The very purpose of the commission is to learn the points of view without taking any position in advance on any phase of the problem.

In the city of Cleveland, where my hospital is located, we have recently completed a survey of the nursing situation which is most constructive and illuminating. It defines all the difficulties, indicates the solutions, and winds up with the conclusion that a lot of things ought to be done, but very little can actually be done because conditions are the way they are. And we can't get enough nurses.

It is my understanding that a wide variety of similar surveys have been conducted over the past few years by various communities and agencies all over the country. Most of them have indicated an even more acute shortage of nurses in the future, have suggested remedial measures, and then have been conveniently buried in the archives of the organizations which conducted them.

I believe that one of the most constructive functions that the proposed National Commission on Nursing Services could perform would be to gather all of these surveys together and make a correlated analysis of their respective findings. This would carry weight and lead to action because it would have behind it the authority and the prestige of the Congress of the United States.

Now in conclusion—here is just a word of warning.

The American public is very patient. It will let things go from bad to worse for a long time; but when they get too bad, Congress will rise up and impose government controls in an effort to accomplish what had appeared to be impossible of attainment under private initiative.

Do we want this to happen in the hospital, nursing and medical fields?

Or are we ready to admit that we in these three professions need help and guidance from a catalytic agent, a correlating agent, which can reconcile our divergent points of view and develop a common solution which will be acceptable to all parties concerned?

MAY FORESTALL CONTROLS

I say, let's get Congress into the picture right now, in order to forestall what some future Congress might do in case we in the professions continue to be unable to solve the nursing problem.

Mrs. Bolton believes in the principle of congressional consultation, not congressional compulsion. She is looking for a way whereby the solution can be found through cooperative efforts implemented by the aid of the congressional members on her commission.

At long last Mrs. Bolton's commission will provide an authoritative audience for the discussion of the problems of the hospital administrator. At long last he will be able to get an official hearing before people who are really concerned about his difficulties, with the realization that some attention is going to be paid to them and some effort is actually going to be made to help him to get adequate nursing personnel.

I want Mrs. Bolton's commission set up because I think it will help to straighten out some of the problems of health care most important in the preservation of the lives of our citizens.

Her bill will be up for consideration by the House foreign and interstate commerce committee early in 1956. I shall attend the hearings and testify on behalf of the bill.

Classify Accounts to Boost Collections

Collection of accounts after the patients have been discharged is facilitated by an orderly classification according to source of payment

GEORGE BRUCE CALDWELL and PAUL J. CONNOR Jr.

THE procedure for collecting accounts after the patient's discharge must be an organized orderly system that is to some degree automatic and standardized for certain credit situations.

The system of credit and collections presented in this article offers a distribution of accounts after discharge as a method of classification and follow-up. The purpose of the distribution is properly to classify the accounts according to source of payment after discharge.

The first step in setting up a distribution of accounts is to establish a reasonable classification that will include all accounts.

To classify accounts receivable according to source of payment, the following categories are used:

A. In-house.
B. Blue Cross.
C. Commercial group and private insurance.
D. Discharged individual pay.
E. Legal action pending.
F. Compensation.
G. Governmental.
H. Outpatient.
I. Collector.

Perhaps the best way to explain the final distribution and classification of accounts is to discuss each category and relate it to the whole.

This is the second, and concluding, section of an article by Mr. Caldwell and Mr. Connor on credits and collections. The first section appeared in the December 1955 issue of The MODERN HOSPITAL.

Mr. Caldwell is administrative assistant, Rockford Memorial Hospital, Rockford, Ill., and Mr. Connor is associate director.

A. In-House

The in-house file of accounts is that group of ledgers to which the daily charges of all inpatients are posted. Each day the ledgers of the previous day's discharged patients are pulled from this file for billing and subsequent transfer to the other categories. The act of removing these discharged accounts from the in-house file and the transfer of these accounts to other files within the accounts receivable are the core of the distribution.

At the time the discharged ledgers are removed from the in-house file, the corresponding admitting and follow-up form is also removed and matched with the appropriate ledger. With the information contained on the follow-up and the final patient's bill in hand, the credit manager and his assistant are ready to start the actual physical distribution of accounts from the in-house file to the other appropriate categories. To identify the accounts properly, the ledger is coded A, B, C, D, and so on, in accordance with the appropriate classification.

B. Blue Cross

The Blue Cross file consists of that group of discharged patients' accounts that have been removed from "A" file and placed in the Blue Cross file. At the time of the distribution, the accounts of all patients who are covered by Blue Cross are placed in this file.

When the ledger is to be placed in the Blue Cross file, the letter "B" is written in pencil in the upper corner of the ledger. After the ledger is coded and it is determined to whom the copies of the bill will be sent, a credit clerk is given the material. This clerk gathers the necessary information and signatures for insurance forms from the record room. She sends a copy of the bill and the necessary forms to Blue Cross. She also sends a copy of the bill to the patient with an estimate of what Blue Cross will pay and an estimated balance due from the patient. The follow-up form is attached to the patient's ledger card and is ready for filing in the Blue Cross file.

C. Commercial Group and Private Insurance

"C" file, or Commercial Insurance, is handled much the same as Blue Cross. All patients' accounts that are covered by hospitalization insurance other than Blue Cross are transferred from "A" file to the commercial insurance file. The procedure for transferring these accounts is exactly the same as the procedure for Blue Cross accounts. However, there are two important considerations relative to the accounts in this file.

First, it is important that an assignment of insurance benefits is included with the copy of the bill and the insurance forms. If no assignment accompanies the bill, the insurance company will pay the patient directly. This results in a different source of payment and the consequent appropriate classification of the account.

The other important consideration necessary for the effective handling of the commercial insurance file is the relationship with the local industrial

firms and insurance companies. Every effort is made to establish definite standard procedures for the proper collection of commercial insurance accounts. Often, these accounts are group insurance plans and handled through the personnel offices of the companies involved. The credit clerk who gathers the information during the immediate post-admission period has developed a file for insurance procedures. This file contains information on whom to contact, what benefits are paid, what forms are necessary, and any other data that it may be of value to collect from each insurance company. As the credit office deals with more insurance companies, more information is incorporated into the file.

Often a patient may be covered by hospitalization insurance through this company and also carry Blue Cross for his family. In this case, the account is placed into Blue Cross file because Blue Cross often pays the hospital faster than commercial insurance companies do. When payment is received from Blue Cross in this case, the balance of the account is then placed in the commercial insurance file pending payment from the commercial company.

If the patient is insured by two commercial companies, the entire account is, of course, placed in this file.

D. Discharge Individual Pay

This file is that group of discharged patients' accounts that are the sole responsibility of the patient. The method by which a patient's account is transferred from "A" file to this file is as follows: At the time of the actual distribution, the patient is sent a copy of the bill; the follow-up form is attached to the ledger card; the ledger card is coded with the letter "D" and placed in this file.

This file, of course, is the real credit problem. It is the accounts in this file that get the routine credit letters; however, credit letters and collection technics will not be discussed here.

This file will contain four types of accounts.

The first type of account contained in this file is the patient's account that is being paid by the patient as agreed by the financial arrangements made at discharge. To control accounts of this type within the file, a subcontrol system is used. This system consists of a small card containing the patient's name, hospital number, date of discharge, and the financial arrangements. This card is made at the time of the distribution and filed by date in a small separate file. The date indicates the time the first payment is due. Each day the cards containing the date corresponding with the day are pulled from this subcontrol file and are matched with the ledgers to see if payment has been made per agreement. If payment has been made, the cards are dated according to the next due payment and are refiled. If the payment has not been made as agreed, the credit manager sends the first of a series of collection letters.

The second type of account found in the discharge individual pay file is the one that has been transferred from some other file; for example, if Blue Cross payment covers only a part of the patient's bill, the balance is transferred from the Blue Cross file to this file by the business office upon receipt of the Blue Cross payment. Transfers are made to this file any time the source of payment changes from some third party to the individual.

The third type is the account that is not being paid and is on its way to the collector. Owing to the fact that many accounts in this file are reviewed weekly, the collection procedure is stepped up to some degree. Consequently, if no payment is forthcoming within 90 to 105 days after discharge or last payment, the account is transferred to the collector's file.

The last type of account found in this file is the late charge. Because of the minimal amount of money involved in late charges, the hospital does not attempt to collect these charges from insurance companies and other third parties. Late charges are always sent to the patient, become the patient's responsibility, and consequently are found in the individual pay file.

E. Legal Action Pending

This file consists of that group of accounts that are pending some type of legal action. Accounts resulting from automobile accidents are quite typical of this file. The method of distribution is a matter of coding the ledger card with the letter "E," copies of the bill being sent to the appropriate party. This file, by nature, contains many old accounts which are kept in this file so that they will not be written off or confused with bad accounts. (*Cont. on Page 64*)

ROCKFORD MEMORIAL HOSPITAL DAILY BUSINESS OFFICE

REPORT FOR 2/28/55

CASH IN GENERAL ACCOUNT

Previous day's balance	$ 50,404.32	
Add daily deposit	6,444.89	
Deduct disbursements	2,431.59	
Net cash balance		$ 54,417.62

ACCOUNTS RECEIVABLE

A. In-House	$ 37,368.73	
B. Blue Cross & Blue Banner	18,563.28	
C. Commercial Group Insurance	24,236.96	
D. Discharged Individual Pay	77,054.13	
E. Legal Action Pending	6,496.55	
F. Compensation	2,244.20	
G. Governmental	10,945.32	
H. Outpatient	21,203.05	
I. Collector	31,975.69	
Total Accounts Receivable		$230,087.91

CURRENT LIABILITIES

Invoices dated in February	$ 33,038.22	
Invoices dated in		
Subtotal Accounts Payable	$ 33,038.22	
Accrued Payroll	$ 43,405.23	
Accrued Specialist Fees	2,240.00	
Accrued Social Security Tax	1,547.71	
Accrued Interest Payable	25,875.00	
Miscellaneous Current Liabilities	$ 2,500.00	
Total Current Liabilities		$108,606.16

F. Compensation

This file contains those patients' accounts in which the source of payment is the patient's employer. Employes hurt on the job are listed in this file. The method of distribution is similar to the handling of accounts in the legal action file with the exception of the code letter and the placement of the account.

G. Governmental

The governmental file contains that group of patients' accounts that are being paid for by some governmental agency. The method of transfer at the time of the actual distribution is as follows: The agency is sent a copy of the bill; the ledger is attached to the follow-up form (as in all cases); the ledger is then coded with the letter "G" and placed in the government file. Because of the time it takes for governmental agencies to process claims, this may contain old accounts, but they are good accounts.

H. Outpatient

This file contains the outpatient balances. Outpatient work is done on a cash basis as much as possible. However, a system of billing within this file must be developed. This article does not propose to offer a system for outpatient collections; that is a complete subject by itself. The outpatient file is merely mentioned here to demonstrate how the outpatient charges fit into the system and to give a complete picture of the accounts receivable. With the exception of Blue Cross patients, there is no distribution of the charges within this account.

I. Collector

This file contains all patients' bills that are in the hands of a collector. Of course, no distribution is made to this file at the time of discharge. All accounts in this file have been transferred from the "D" or individual pay ile.

After the patients' accounts have been distributed to the foregoing files at the time of discharge, the transfers from the "A" file (in-house) and the transfers to the other files are totaled, recorded on a transfer slip and sent to the business office to be transferred on the books. This transfer slip is the posting medium that makes the proper entry on the hospital books possible.

As previously mentioned, these subaccounts of accounts receivable are the core for this credit system. Because of the significance of this part of the system, it may be well to review some of the general principles of the distribution and transfer of patients' accounts into the various classifications or files.

1. All patients' accounts are in "A," the in-house file, at the time of discharge.

2. Immediately after discharge, the patient's account is distributed into the appropriate file according to source of payment. No account is transferred to a file unless the source of payment has been determined and is confirmed.

3. During the follow-up period after discharge, a patient's account may be transferred from one file to another as the source of payment changes. As the inactive accounts become evident, there is an established method by which they are routed to the collector.[7]

USE OF STAMPS TO CLARIFY BILL

Hospital bills are traditionally not clear to the patient. One device that may be used to clarify the bill to the receiver of that bill is the use of stamps. At the time of distribution, the stamps are available and used as the bills are prepared for mailing. Some examples of these stamps follow.

No. 1.

A COPY OF
YOUR HOSPITAL BILL
HAS BEEN SENT TO

Stamp No. 1 is placed on the patient's hospital bill when someone other than the patient is responsible for payment. This stamp informs the patient that insurance forms have been processed and mailed.

No. 2.

WE SHALL SEND YOU A STATEMENT
AS SOON AS WE RECEIVE PAYMENT
FROM YOUR HOSPITAL INSURANCE

If the patient is insured by more than one company or if the insurance benefits cannot be estimated, stamp No. 2 is placed on the patient's bill. If a balance is due on the patient's bill after the insurance has been paid, the stamp will warn the patient to expect the bill, because of the use of this stamp.

[7]This distribution of accounts is adopted from the system used at Rockford Memorial Hospital, Rockford, Ill.

No. 3.

TO BE PAID AS PER
SIGNED AGREEMENT

If the patient has no insurance or other third-party arrangement for payment, he has signed an agreement to pay on or before discharge. The purpose of stamp No. 3 is to remind the patient of his obligation. The agreement is written on the lines below the statement.

No. 4.

THE ABOVE CHARGES, FOR
ITEMS USED BY THE PATIENT
WERE NOT AVAILABLE AT
DISCHARGE AND THEREFORE
WERE POSTED A DAY LATE

Stamp No. 4 is obviously a proposed solution to the late charge problem. If the patient has paid cash on discharge, and another charge is then placed on the ledger, this stamp is placed on the patient's bill. If the charge is minimal in proportion to the total amount of the bill, it is written off. However, if the charge is significant, the bill bearing this stamp is sent to the patient. Late charges are also explained on the back of the patient's bill.

No. 5.

HOSPITAL INSURANCE BENEFITS
ASSIGNED TO THE
ROCKFORD MEMORIAL HOSPITAL

This stamp is used on all commercial insurance cases. The patient's copy of the bill and the insurance copy must be marked with this stamp. This is one method of making certain that assigned benefits are made payable to the hospital.[8]

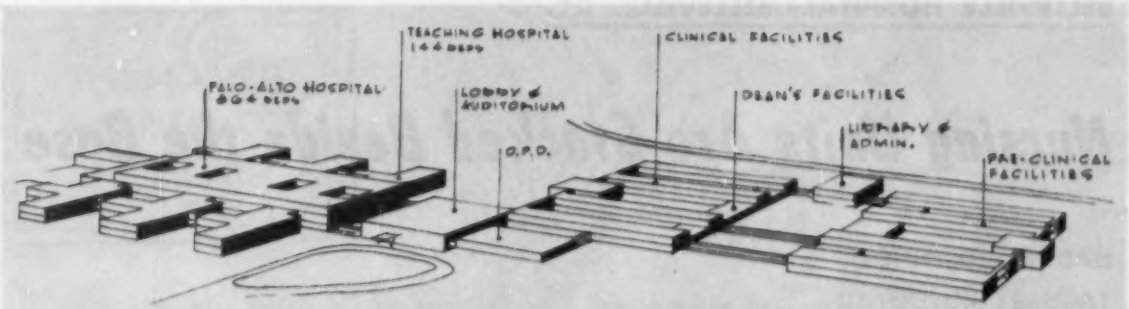
ADMINISTRATIVE CONTROLS

Effective control of accounts receivable is an essential part of hospital administration. There are two ways to accomplish such control. First, the credit system must be supervised at certain key points and, second, the administration must receive periodic reliable financial reports from the credit and business offices based on routine analysis of accounts receivable. A good system of credit and collections lends itself to this control.

One method of control in this pro-

(*Continued on Page* 140)

[8]Stamps used at Rockford Memorial Hospital, Rockford, Ill.



Schematic study of the Palo Alto Hospital showing its integration with the medical-teaching facilities of Stanford University. Clinical, ancillary and administrative facilities serve the adjoining existing hospital.

It Is Better to Build Out Than Up

The horizontal hospital promises a new point of balance between cost and efficiency

ISADORE ROSENFIELD
ZACHARY ROSENFIELD

A HOSPITAL has to be many things. From the patient's point of view, first of all, it must feel good to be in and it must be efficient. Efficiency implies a building so skillfully contrived and equipped that it lends itself to convenient operation. The phrase "feel good to be in" used to mean visually pleasing, but today it is broadened to include the perceptions through all sensory organs: hearing, smelling, feeling.

If a patient's room is designed to look attractive but suffers from external or internal noises, or from kitchen or laboratory odors, or feels cold because of drafty construction or crude air conditioning, or has a depressing outlook, then in terms of our definition the "attractive" room is not attractive because it *does not feel good to be in.*

The patient may or may not be interested in the economics of the hospital while he is sick, but as a citizen and a consumer he is profoundly concerned because, on his discharge from the hospital, the economic factor will appear before him as a bill for services.

Dr. S. S. Goldwater used to say that hospital planning is hospital administration. When the architect sets the plan, the mechanical systems and the equipment, he sets the conditions under which the hospital is to be administered to a considerable extent. A well designed hospital can be badly administered, but a poor one cannot be administered well even by the best administrator. A badly designed hospital which is poorly administered is costly to operate and to maintain. A recent U. S. Public Health Service publication shows that in hospitals of 250 beds and over, the difference between having 202 employes or 183, a difference of 19 employes per 100 patients, amounts to a difference between having an operating deficit of 1.4 per cent or a surplus of 10.2 per cent.[1]

Some hospital designers (administrators as well as architects) have been struggling in the postwar era with this triple and intertwined problem of esthetics, efficiency and economics. Many things have been tried in recent years. To mention a few: There is the small, self-service room, first introduced at Peter Bent Brigham Hospital in Boston, which a few years later blossomed out with the addition of the decentralized nursing stations and utilities in the corridors, plus outside circulation balconies, at the Kaiser-Permanente Hospitals in California. Another example is the attempt to replace labor with mechanical devices and the shortening of distances to eliminate steps through such means as Neergaard's double corridor, Friesen's vertical distribution core, and Rosenfield's (Beth-El) placing of the decentralized nursing stations and utilities inside the patients' rooms.

The double corridor and the vertical distribution core cause buildings to be chunky and relatively multistoried. On the other hand a good many hospital buildings are many-storied without a reason. The reasoned ones are brave and worthy attempts at solving problems. Unfortunately there have been no objective evaluations of the results of any of the experiments. We believe, however, that experimentation, even unevaluated on a formal basis, is better than no experimentation at all.

Some of us did not wait for the war to end. One of the principles we

(Continued at Bottom of Page 66)

The authors are architects-hospital consultants, New York City.

[1]Income and Expense Ratios of General Hospitals—1954. Public Health Publication No. 407, U.S. Govt. Printing Office, 1954.

BELLEVILLE HOSPITAL, BELLEVILLE, ILL.

Nursing Units Are Stacked Beside the Base

ISADORE ROSENFIELD
ZACHARY ROSENFIELD

BELLEVILLE, ILL., across the Mississippi from St. Louis, had a 1950 population of 33,000 and, in its county and trading area, about 206,000. There is now a general hospital in Belleville and others in the county, but they are inadequate to this primarily farming community.

The proposed hospital has an initial capacity of 86 beds and even in its ultimate capacity of 154 beds* would be inadequate to meet the needs of the community were it not for the fact that those well able to afford it can see specialists and be treated in the hospitals of St. Louis. However, the 10.5 acre site and the open-end planning should make it feasible to expand this hospital still further in the future. The other hospitals in Belleville and in the county are also expanding so that the area has the prospect of being fairly well supplied with hospital services.

Because of the largely farming and trading character of the area, hospital building money is not easily obtained; and the architects were asked to design so as to stretch the dollar to its limit. The community survey and initial planning began toward the end of 1950. Since then, study after study had been made to bring costs down.

An architect's control of costs is of course limited. He

*Since this writing the hospital has decided to build the entire 154 beds.

Architect's rendering of the Belleville Hospital, Belleville, Ill., with a capacity of 154 beds. Almost 56 per cent of the patients will be horizontally contiguous to the diagnostic-therapeutic services; 44 per cent will be one story removed.

Horizontal Hospitals: It's Better to Build Out

(*Continued From Page 65*)

have contributed to hospital planning is that of horizontal contiguity to which we began to give expression in the middle Thirties, and to which we gave written expression in an article in the *Architectural Record* in the early Forties, which the Hospital Facilities Division of the U. S. Public Health Service employed in its prototype hospitals and which is today the predominant expression all over the world. Curiously, the experimenters with the double corridor and the vertical core have generally not coupled their work with the principle of horizontal contiguity but continue to organize the hospital on a vertical basis in one block.

A few years ago we integrated the principle of horizontal contiguity with the mechanized, short-wing, multi-story service core principle and at least in part with the double corridor (Beckley Memorial Hospital). The results of this integration proved to be quite satisfactory. This hospital was less costly per bed than several others in the series with Beckley.[2]

Hospital construction has been costly. There are those who believe that high first cost is justified if perpetual operating cost can be reduced, and there are those who hold that high first cost

[2]A Hospital Chain 250 Miles Long. Architectural Forum, August, September and November 1953.

THE MODERN HOSPITAL OF THE MONTH

Perspective of the garden at Belleville Hospital which will be placed between two connecting corridors.

does not have control of the economy of the country or of the locale, nor does he control local trade practices. His first safeguard is to design the hospital to such minimums of *areas* as are consistent with proper hospital function. His second safeguard is to develop and specify his hospital in a straightforward, economical manner and hope that the factors over which he has no control will provide no surprises.

Some of the architects of this team have begun to sense during the last few years that building low rather than seeking verticality may result in building space economy and at the same time in simpler and, therefore, cheaper construction technics. Simultaneously, they have been growing increasingly aware of the desirability of horizontal contiguity among the ancillary departments for administrative economy's sake and between the diagnostic-therapeutic facilities for medical efficiency's sake.

Accordingly all ancillary or service departments in this final scheme are on the basement level and all diagnostic-therapeutic departments are on the first floor. The idea of this kind of grouping is not new. Paul Nelson in his St. Lo Hospital did it earlier for the same reason that we are doing it here. Others have done it to create a broad base in accordance with the formal cliché created by the Lever Bros. Building in New York. Both Paul Nelson and the cliché followers stacked the nursing units on top of the base. (Paul Nelson did it before the Lever House cliché was founded.)

The Belleville Hospital presents a departure with respect to the placing of the nursing units inasmuch as the stack of nursing units is not placed over the base, but beside it. We feel that this is nevertheless esthetically pleasing, but we had functional considerations foremost in mind when we did it. Consistent with our principle of placing patients horizontally contiguous to the vital diagnostic-therapeutic services, in our scheme during the 86 bed stage, when all the beds will be on the first floor level, 100 per cent of the patients will be horizontally contiguous to the diagnostic-therapeutic services, and administration and visitors will also be on the same level. As a result of this, all movement incidental to these services would not involve either stairs, elevators or dumb-waiters; and only one elevator would be needed to effect movement between the ancillary services in the basement and the hospital proper on the first floor.

In the second, or 154 bed stage, almost 56 per cent of the patients (surgery and maternity) will be horizontally contiguous to the medical vitals of the hospital, which are the reason for the patient's being in the hospital in the first place, and only 44 per cent (mostly medical and pediatric cases) will be removed one story from the medical vitals, and at that time the second elevator would be installed.

We know that this plan, based on the concept of horizontal contiguity between the patient and the medical services, among the medical services themselves, and among the ancillary services, is sound beyond dispute, but the extent of building economy inherent in those principles can

(*Continued on Page* 68)

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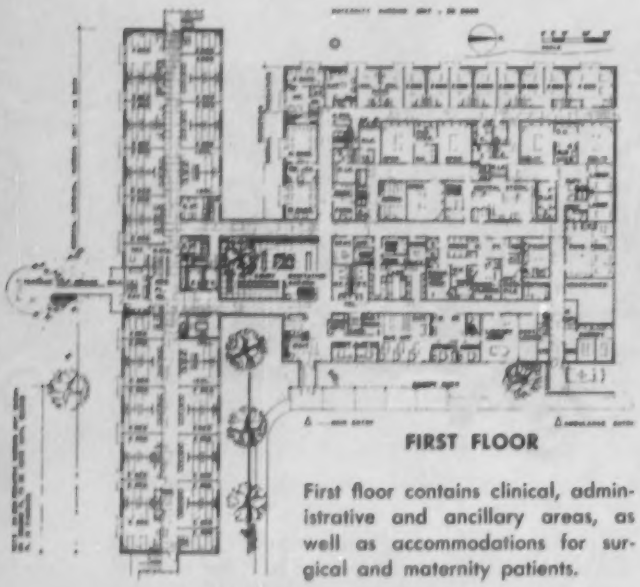
and high operating costs as well may be justified in order to achieve efficiency or even monumentality. However, many hospitals are not able to reach the building stage because of the high first cost and others come to life in a very stilted form owing to the slashing down process to bring down first cost. It would seem, therefore, that we must continue to experiment in the quest for hospitals that would cost less to construct and to operate, and which will be achieving ever higher levels of efficiency. This is largely the responsibility of the architect as planner and builder.

In the last few years a series of circumstances led us to the decidedly horizontal hospital which promises to provide a new point of balance between cost and efficiency. It is not a panacea and has yet to prove itself an operating advantage, but it makes a rather radical departure from the several conventional types. The following are the considerations which led us to the horizontal hospital:

1. We know from experience that a building without a basement, where the first floor is an unreinforced slab on earth, will be less costly than one which has a basement and where the first floor has to be structurally self-supporting.

2. We also know that under most building codes a building of one or, in any case, of only a few stories could have an economical roof and intermediate floor construction, as well as other economical elements, as compared with the fully fireproof construc-

(*Continued at Bottom of Page* 68)



FIRST FLOOR

First floor contains clinical, administrative and ancillary areas, as well as accommodations for surgical and maternity patients.

OUTLINE OF CONSTRUCTION COSTS

Number of beds	154
Total construction cost	$1,965,810
Cost per bed	9,660
Square feet per bed	420
Cost per square foot	23

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made by The Modern Hospital each month. Belleville won a citation for good design over 74 entrants in the health category in the 1955 Design Awards contest of "Progressive Architecture" magazine, to be published January 1956.

Belleville Hospital, Belleville, Ill.

(*Continued From Page 67*)

be shown only by area and cost economy as shown in the table on the opposite page.

This being a small hospital and not a fully one-story hospital because of the nature of the terrain, the area and construction economy need not be expected to be of a startling nature. Inasmuch as the hospitals listed in the table were built at various times since the Korean war and with varying specifications, we decided that to report them in terms of their actual cost per square foot would only serve to confuse. There can be good reasons for area-per-bed variations, too, but area comparisons come nearer the truth than cost per bed. However, to heighten the sense of difference between Belleville and other recent Illinois hospitals in terms of cost, we used the average current cost of $23 per square foot. Since the Illinois data had no hospital corresponding to the ultimate bed capacity of 154 at Belleville, we used the Arkansas example.

The first two hospitals in the table which are within two beds of the capacity of the first stage of Belleville average 670 square feet per bed as against 618 square feet at Belleville, showing a space economy of 7.8 per cent. If we include the other four hospitals short of the Arkansas example, the average area per bed would be 747 square feet and Belleville's advantage would be 17.4 per cent.

At the 154 bed stage, Belleville's advantage over the

Horizontal Hospitals: It's Better to Build Out

(*Continued From Page 67*)

tion necessary in multistory hospitals.

3. We likewise know that a one-story hospital would use no elevators and that a few-storied, spread out hospital would require fewer elevators than a hospital of the same capacity with its elements stacked vertically. Elevators are extremely expensive elements in any building.

4. What is even more important is that clinicians have been asking that we place operating, x-ray, laboratory and other medical services side by side. The St. Lo Hospital in France, by Paul Nelson, is one of the earliest in which the plan responds to this clinical desideratum.[3] To accommodate so many services side by side makes it practically implicit that these services should be located on the ground floor. The doctors are perfectly right in their demand for horizontal contiguity among the clinical services. For example, in today's practice a surgeon is no longer satisfied with merely *seeing* the x-ray plate. He wants to have a verbal consultation about it with the roentgenologist, but he does not have time to go to see him on some other floor. Doctors find that in the average hospital they are forced to do a great deal of traveling within the hospital.

5. The clinician, who is deeply concerned with the close relationship among the clinical facilities, may not be very much concerned with where the patient comes from or where he goes after treatment; but both considerations are equally important. This is where the architect comes in. *We think it is important to have the clinical services horizontally related to each other and it is also important to have the patient situated horizontally contiguous to the clinical services.* This is our original thesis of horizontal contiguity expanded to include the contiguity among the clinical departments. When these are added together we have a relatively flat, horizontal hospital instead of a base with a tower superimposed on it.

Let us now consider some of the planning experiences with this type of hospital and let us also consider some of the limitations and problems involved. Our first experience was with the small hospital at Belleville, Ill.,[4] described in the accompanying article.

[3]Architectural Forum, September 1949.

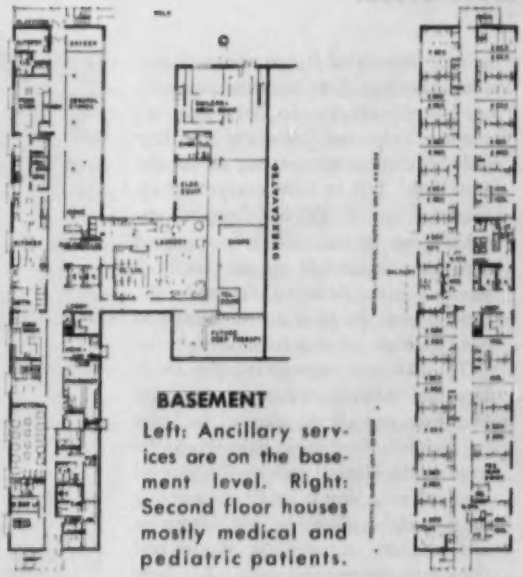
[4]In association with Hellmuth, Obata and Kassabaum with Charles E. King, Associate.

ILLINOIS HILL-BURTON HOSPITALS OF 84 BEDS AND UP AT $23 PER SQUARE FOOT (CONSTRUCTION COST)

Location	Beds	Sq. ft. per bed	Construction cost per bed
Fairfield.....	84	607	$13,961
Vandalia.....	84	733	16,859
	108	603	13,869
La Grange.....	99	1010	23,230
Mount Vernon.....	117	760	17,480
Taylorville.....	117	773	17,779
Average.....		737	
Fort Smith, Ark.[1].....	150	555	12,765
Belleville.....	86	618[2]	14,214
	154	420[2]	9,660

[1] In the absence of a 150 bed example in Illinois

[2] Figures from final or working drawings



Arkansas example would be more than 24.3 per cent. The figures show the economic advantage in terms of area and corresponding dollars alone. They do not take into consideration the saving which could be made by employing building technics and labor savings peculiar to one and two story-plus-basement construction as against the four and more stories-plus-basement which the average hospital of similar bed capacity would have.

What is the magic? None whatever. Repeated studies of multistory hospitals *vs.* those based on the principle of horizontal contiguity show that the horizontal hospital avoids the enormous waste of space inherent in repeating circulation, service and mechanical equipment areas floor by floor in the typical vertical hospital. To mention a few representative repetitive areas we have: elevator spaces, elevator lobbies, stairs and the corridor in front of them, slop sink closets, areas for chimneys and/or smokestacks for incinerator and boilers, ventilation duct, pipe and conduit spaces.

This hospital could have been resolved even more economically on a strictly one-story basis, had the site been flat. However, the principle of horizontal contiguity need not rest on construction economy alone. If it broke even with the conventional hospital insofar as first cost is concerned and even if it cost more than the conventional hospital, it would still be justified on the basis that it is good for the patient, because it facilitates the process of diagnosis and therapy.

MEDICAL CENTER, SAN JOSE, CALIF.

Our next experience was with the 334 bed Medical Center Hospital at San Jose, Calif.[5] This is to be a hospital surrounded by individual doctors' offices which will be provided with some of the diagnostic and therapeutic facilities normally found in a hospital. Consequently, the corresponding facilities in the hospital are slightly smaller than usual for a hospital of this size.

This is a wholly one-story scheme (not even a basement) for which reason the construction methods could be very cheap. The builder[6] estimates that this hospital could be built for $19 per square foot. But even disregarding this important estimated economy, this hospital comes to 387 square feet per bed as against the California average of 563 square feet per bed (Table 1). At the current average cost of $22 per square foot for conventional, multistory hospitals in California, the construction cost of this hospital would be $8514 per bed, while the average construction cost of conventional multistory Hill-Burton hospitals in California of 120 beds and over is $12,398 per bed.

PALO ALTO-STANFORD HOSPITAL

With the exception of research which will be done at the medical school, Palo Alto-Stanford University Medical School Hospital[7] is a fairly complex hospital, as it has to satisfy the unusually high requirements of a community accustomed to high medical standards and the teaching needs of the proposed medical school of Leland Stanford University. It should be further noted that this hospital does not have a heating plant because steam is to be supplied from the university's central steam plant. Nor is the outpatient department included in the calculations, although many of the clinical services in the hospital proper are sized to serve the outpatient department which, in the circumstances of this community, is considered purely a teaching adjunct of the medical school. On the other hand, it is to be noted that the clinical, ancillary and administrative services in this new hospital are sized to serve the adjoining existing 200 bed Palo Alto Hospital building.

While San Jose does not contemplate expansion, the Palo Alto-Stanford Hospital is planned to grow from 432 beds at the first increment to an ultimate of 1000 beds. This hospital carries out the principle of "horizontal contiguity" to a considerable extent;

[5] With Rex W. Allen.

[6] Paul A. Hungate.

[7] With Rex W. Allen.

in fact, it carries it out more clearly than does San Jose in some respects, but not in others. In San Jose, all nursing units and both the ancillary and the clinical services are all on the same level, but to have everything on one level in a 1000 bed hospital appears to be impractical. It is reasoned here that inasmuch as the ancillary services have little to do with the clinical ones there is no advantage to having them on the same level.

This leads to segregating the ancillary and administrative functions on one floor and all the clinical facilities on another. One logic here would be to place the clinical core on the ground level, surrounding it by all the nursing units, and to place the administrative and ancillary services on the second floor without nursing units. But here again we realized that from the point of view of physical space and distances involved in a 1000 bed hospital, the placing of so many nursing units on one level is impractical. It became obvious, therefore, that 1000 beds would have to be handled on more than one level. What then would make a practical arrangement?

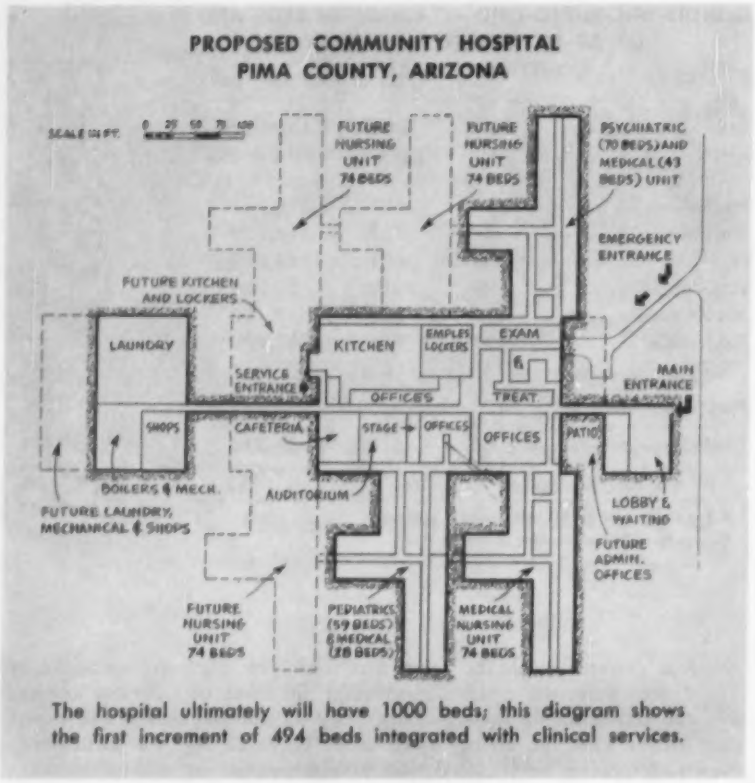
The following were taken into consideration:

1. About 50 per cent of the patients are surgical, and inasmuch as they are primarily concerned with x-ray department and operating rooms, it is logical to place the surgical nursing units horizontally contiguous to these departments. Such patients have to be moved in bed or on a stretcher, and the best way to move such patients is on one level rather than up and down in elevators.

2. It follows from this that it is far less vital for medical, obstetrical, pediatric and psychiatric patients to be contiguous to the major clinical facilities, such as x-ray, surgery and so on, because such patients are either not generally concerned with x-ray or surgery, or they are ambulant and do not have to be moved while in bed or on a stretcher. In terms of this logic it was decided to place psychiatric, pediatric and medical nursing units on the ground floor and correspondingly to assemble the ancillary and administrative services in the core of that level.

It is not denied, of course, that the pediatric cases are frequently surgical. Nor is it denied that medical cases are primarily concerned with the laboratories, or that psychiatric patients need access to encephalography. But a division had to be made in a hospital planned to an ultimate capacity of 1000 beds and the foregoing seemed to make the most sensible one within the framework of horizontal contiguity. Most of the patients of the ground floor clinical categories would be ambulant and it would be easy to move them to the second floor clinical services by elevator when necessary. Laboratory specimens hardly require moving the patient, and specimens are best moved by means of the pneumatic tube system. Providing access to gardens for pediatric and psychiatric patients, on the other hand, is a good reason for placing these categories on the ground level.

3. This leaves for consideration the question of where to place obstetrics. In the San Jose example this service was placed on the ground floor, but in a 1000 bed hospital it did not seem feasible to attach those nursing units horizontally to the service core. Inasmuch as the obstetric service is quite self-contained, it was decided to place it on top of the service core or on the third floor.



The hospital ultimately will have 1000 beds; this diagram shows the first increment of 494 beds integrated with clinical services.

PIMA COUNTY, ARIZONA

In the case of this proposed hospital[*] we had the further opportunity of testing the principle of horizontal contiguity between the pertinent patient beds and the horizontally integrated major clinical services in a 1000 bed hospital. The differences to be noted here from the Palo Alto example are that this project has a steam plant and an outpatient department; also that the cost per square foot is $20.

The 494 beds which will comprise the first increment will have 498 square feet per bed and represent a construction cost per bed of $11,000, or a gross cost of $13,400 per bed. At the 1000 bed stage the area per bed comes to 422 square feet and the construction cost per bed is $9282.

PROMISE AND LIMITATION

In the Belleville example the surgical and obstetrical beds are horizontally contiguous to the medical-professional services. Medicine and pediatrics will ultimately be on the second floor. Even though there is less reason for horizontal contiguity between medicine and pediatrics and the several medical-professional services, such contiguity is nevertheless desirable. But irregularities in the terrain made it impractical to place additional nursing units horizontally contiguous to the core. We may,

[*]With Scholer, Sakellar and Fuller, associated architects.

therefore, draw the conclusion that the principle of horizontal contiguity works best with an extensive, level site.

In San Jose, where the site is of ample dimensions and quite level, it was possible to place a 334 bed hospital on one level, but in the case of Palo Alto and Pima County equally level and extensive sites proved of no avail to accommodate 1000 beds on one level. This leads us to the second conclusion: that even with an ideal site, the limit of one-story planning appears to lie somewhere between 300 and 400 or, at the most, 500 beds.

In the cases of Palo Alto and Pima County, a clear break was made between the ancillary and administrative facilities on the one hand and the clinical or professional on the other. Thus, the clinical floor of the core, in addition to operating, x-ray and laboratory units, also contains central supply, pharmacy, physical medicine, and even medical records. In other words, the adjuncts which the doctors use are all on one floor and closely integrated. This is convenient for the doctors and therefore good for the patients. The ancillary and administrative services on the ground floor are closely integrated with each other, but of course the nursing units on that floor are there only because they could not be on the same level with the other beds.

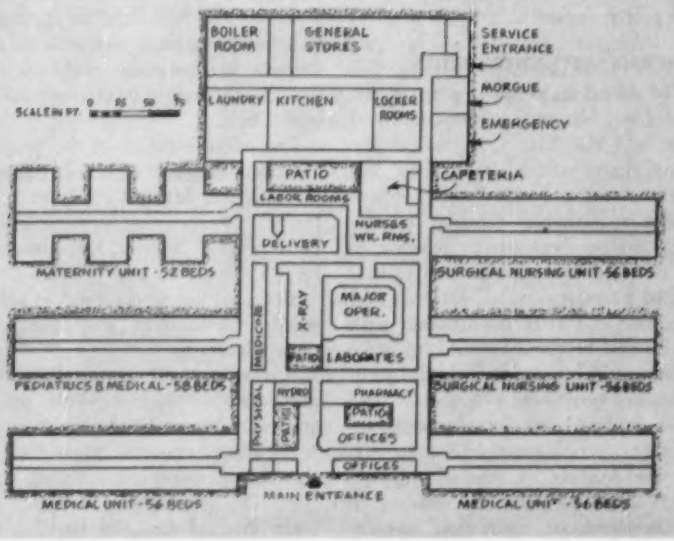
TABLE I—LARGE HILL-BURTON CALIFORNIA HOSPITALS[1] AT $22 PER SQUARE FOOT (CONSTRUCTION COST)

Location	Beds	Sq. Ft. per Bed	Construction Cost per Bed	
San Rafael.....	120	591	$13,002	4 story
Burbank.....	127	524	11,528	3 story
Arcadia.....	137	567	12,474	Multistory[2]
Bakersfield.....	161	682	15,004	4 story
Richmond.....	165	600	13,200	5 story
San Diego.....	234	536	11,792	9 story
Los Angeles.....	253	505	11,110	Multistory[2]
Castro Valley.....	254	507	11,154	4 story
San Jose.....	286	560	12,320	4 story
Averages.....		563	12,398	
San Jose Med. Center	334	387	8,514	1 story

[1] Data furnished by State of California Bureau of Hospital Survey and Construction.
[2] Number of stories not otherwise specified.

MEDICAL CENTER HOSPITAL, SAN JOSE, CALIF.

A 334 bed hospital surrounded by individual doctors' offices. This is a wholly one-story scheme, with not even a basement. Note integration of patient areas with related clinical areas.



The Kaiser system requires small nursing teams operating under a leader. Nurses have not yet been unionized, but it is conjectured that even now a nurse leading such a small team could very well take the attitude that she is doing supervisory tasks and should be remunerated accordingly. Thus, on each nursing unit, instead of having one supervisor there would be four to six in addition to the supervisor of the nursing unit as a whole. The economic implications of this caused us to give up the Kaiser type of nursing unit.

We never accepted the "self-service" room as valid, and unless its originators can offer some studied conclusions concerning this experiment we do not see how we could make use of it. We fear that when a patient is very sick he is not able to reach out for the close-by conveniences, and when he is convalescent, it would generally do him good to wend his way to them. In the meantime, easy access to the patient for medical and nursing attention is blocked by the "conveniences."

Pursuant to repeated studies we found that the double corridor nursing unit requires from 9 to 12 per cent more space than do the same number of beds arranged on a single corridor. In addition, the consequent windowless services add considerably to the mechanical load of ventilation, electric current, and so on. While the double corridor shortens the length of the building it complicates circulation and supervision. But it certainly shortens the nursing unit. We find that the double corridor is suitable only to rela-

(*Continued on Page 152*)

At the beginning of this article we mentioned the several experiments in planning which had been contributed in recent years. We have high respect for these efforts and try to test them out in conjunction with our own ideas. Let us consider the principle of the decentralized nurses stations and utilities, and outdoor circulation (à la Kaiser-Permanente). The San Jose nursing units are planned on these concepts, which contribute to economy of space. But in the Palo Alto project we had to give up the idea and we have accordingly revised Belleville, where we also based our original studies on these "Kaiser" principles.

U.S. Grants Stimulate Hospital Research

Public Health Service program is aimed at studies that will improve hospital and health care

JOHN W. CRONIN, M.D.
LOUIS BLOCK, Dr.P.H.

BIOPHYSICAL and biochemical factors do not fully or adequately explain health and disease. Social factors must be included. At the present time we know little about this relationship. Analysis, studies and demonstrations utilizing pertinent data are necessary to the development of improved programs for health and medical care.

Clinical research has been operating at an ever-increasing pace for the last decade. Research in the field of hospital and medical care for many reasons has lagged. It was inevitable that the community with its social implications and the relationships of its people would be participants. The sociologist, the economist, the anthropologist and the biostatistician have joined with the health professions and related medical care groups to try to reduce the gap between the resultant effects of clinical research and its administrative application.

There is great need for applied research which would permit the development of methods of education and methods of providing service that will most effectively, economically and adequately raise the level of medical care and health practices to the individual and the communities. Such applied or administrative research is now of greatest importance in order to achieve an adequate provision of patient care which in itself is currently recognized as a necessary part of our standard of living.

Dr. Cronin is chief, Division of Hospital and Medical Facilities; Dr. Block is chief, research grants branch, Division of Hospital and Medical Facilities, Public Health Service, Department of Health, Education and Welfare, Washington, D.C.

Research in the hospital field is not coordinated, just as hospital services and resources are not integrated. The amount of known research undertaken in the past and presently under way has not been developed on an effectively planned basis. One result is a scarcity of information on the areas of needed research, the extent to which these needs are being met, where and by whom research is now being undertaken, and what utilization is being made of the facts and information so developed.

The Public Health Service, in company with universities, schools, organizations, associations and individuals interested in this field of endeavor, has long recognized this lack. The needs cannot be met by any one group or organization or by any one hospital; rather the combined efforts of all are essential for ultimate success which is so urgently needed.

CONGRESS AUTHORIZES FUNDS

The American people recognize this need for additional information and facts, and the 81st Congress of the United States enacted Public Law 380 which authorized the Public Health Service to "conduct research, experiments and demonstrations relating to the effective development and utilization of hospital services, facilities and resources, and after consultation with the Federal Hospital Council, to make grants-in-aid to states, political subdivisions, universities, hospitals and other public and private nonprofit institutions or organizations for projects for the conduct of research, experiments or demonstrations relating to the development, utilization and coordination of hospital services, facilities and resources."

For construction purposes under the Hospital Survey and Construction Act, the Congress through fiscal year 1955 appropriated $703,500,000. As of June 30, 1955, $671,000,000 of these federal funds were being matched by $1,385,000,000 of state and local money for the construction of more than 2500 hospital and related health facility projects. Thus the total program exceeds $2 billion and, while the 81st Congress in 1949 recognized the significance of research activities, no funds were made available to conduct research, experiments or demonstrations. The Appropriation Act for fiscal year 1956, in making available $111,000,000 for the Hospital Survey and Medical Facilities Program, authorized the expenditure of a sum not to exceed $1,200,000 for research activities. Thus, for the first time, an appropriation has been made available to seek answers to the many problems confronting the nation in the hospital and health field.

The administration of the program has been assigned to the Division of Hospital and Medical Facilities in the Bureau of Medical Services of the Public Health Service, Department of Health, Education and Welfare.

The program is designed to aid research, experiments and demonstrations relating to:

1. The needs of communities, of the population at large, and of selected groups for hospital and related services.
2. Measurement of resources available and necessary to meet these needs.
3. The planning of hospitals and other medical facilities both in rela-

tion to community needs and resources, and from an architectural or functional design standpoint.

4. Methods of increasing the availability and effectiveness of hospital and medical services to the public and of improving the quality and efficiency of hospital and other medical services by clinical, administrative, financial and educational means.

5. Methods by which services of hospitals and other medical facilities can be improved or the cost of such services lowered through coordinated efforts of hospitals and other medical facilities with one another on a regional or other basis.

This grant program will be administered under the same policy and rules as apply for other Public Health Service research grants programs. Applications submitted to the surgeon general will be studied and reviewed by a study section composed of authorities in the fields of hospital administration, medical care, socio-medico-economics, biostatistics, anthropology, sociology and basic scientific research. Following recommendations as to priority of the applications by the study section, the surgeon general, as provided by the act, will consult the Federal Hospital Council concerning the project applications and then award the research funds to the selected applicants.

CHALLENGE TO HOSPITALS

The fact that the Public Health Service has funds to conduct research, demonstrations and studies in the aforementioned fields does not in itself take care of all the need that exists. In the research grant phase of the program lies one of the greatest challenges ever offered to those interested in improving hospital facilities and services. The Public Health Service itself has only the limited responsibility of administrative details in the handling of these grant funds. Full and direct responsibility for and, in the end, the success or failure of, this program depend upon the vision, interest and ability of those outside the federal government as well.

Although many hospitals in this country operate efficiently, and a high standard of patient care exists, we need improvements. This program presents an opportunity to study and to learn more about patient care and related health problems and to demonstrate improved methods on a nationwide scale.

NO INTERFERENCE

It should be kept in mind that accompanying the purpose of the grants is the complete acceptance of a basic tenet of the philosophy upon which the scientific methods rest, that is, the integrity and independence of the research worker and his freedom from control, direction, regimentation and outside interference. Such a philosophy is inherent in this program as it is in the administration of all Public Health Service research grant programs.

The widest latitude is allowed by the wording of the law to permit such research, study and demonstrations in the hospital and related health fields. There is almost universal agreement that needed information is lacking in many relatively unexplored areas. At the same time, it is also recognized that there are few current methods that are not susceptible of improvement.

Improvement of the conditions that exist in hospitals today can be achieved through this type of research grant program without loss to the hospital of its individuality, initiative and local responsibility. Rather, this type of coordinated effort between the federal government and local groups acts as a stimulus to enlarge responsibility, to improve patient care, to retain competent professional personnel, and to be more efficient in the expenditure of private and public funds.

There is no doubt that there is need for improving medical and hospital care. It is imperative that the leaders in the hospital and health fields give serious consideration to every method that will improve standards of patient care and to take full advantage of this opportunity to provide the necessary information and to provide a good solid base from which to operate to the ultimate benefit of all.

NUMBER OF REQUESTS FOR RESEARCH GRANTS

1. Coordination	**13**
Projects such as statewide, metropolitan area, and local regional demonstrations.	
2. Administrative Areas	**21**
Projects such as hospital supplies and equipment safety lists; hospital utilization study; methodology for evaluation of patient care; legal aspects of hospital service; patient care and its organizational relationship; rôle of the hospital in education of health personnel; application of modern personnel management technics to hospitals, and research in methods improvement.	
3. Facility Planning	**3**
Projects such as study of architectural errors in construction of general hospitals; space and equipment utilization in smaller hospitals, and architectural study of psychiatric facilities.	
4. Community Needs	**10**
Projects such as ambulatory programs for patient care; the hospital and its community relations; future needs for hospital facilities; hospital planning and licensing laws, and adequacy of existing hospitals in meeting local needs.	
5. Clinical Areas	**7**
Projects such as manual for hospital physical therapy department; audit of pharmaceutical services in hospitals, and an experimental study of the function of general duty nurses in the area of record keeping.	
Total	**54**

University of Pittsburgh studies on applications of scientific management to nursing service in the operating room point up the fact that

Good Equipment Means Better Nursing

RUTH PERKINS KUEHN

IN THE course of the studies made at the University of Pittsburgh on operating room procedures, a variety of related problems not covered by the scope of the studies themselves have become apparent. These range from simple suggestions concerning operating room supplies to more nearly complete recommendations for the redesign of hospital equipment.

Some of the suggestions came about through the work carried on in connection with the studies as reported upon here. Others were the result of requests from manufacturers for evaluation of their products. In other cases, hospital employes requested specific help with some of the problems that confronted them.

Mrs. Kuehn is dean of the school of nursing, University of Pittsburgh.

This is the fourth and last of a series of articles from the University of Pittsburgh on the results of studies of operating room nursing procedures. The preceding articles covered: processing used rubber gloves (October); standardizing the surgical setup (November); the surgical prep shave (December).

Edna Prickett, who directed these studies, is now operating room consultant with the National League for Nursing. Carl Linderoth, who worked with Miss Prickett, was a member of the Methods Engineering Council of Pittsburgh.

CENTRAL SUPPLY CART

One example of the last was a request made by one medical center hospital for a suitable means of dispensing material from central supply service.

Initial survey of the existing method showed that the equipment being used was not designed for central supply service use. Further investigation indicated that no such special purpose equipment was available but that many substitutions were in use. These are summarized on the following page together with some of their limitations.

Original delivery cart used by central supply service was too heavy and awkward for personnel to handle.

Sample cart built in cooperation with manufacturer has proved to be much more satisfactory than original.

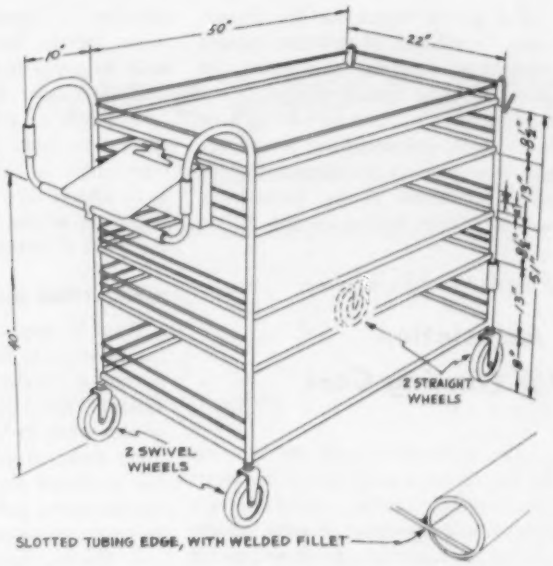


Diagram of the cart shown on opposite page designed to meet the needs of a 300 bed hospital.

1. Food conveyor (tray truck).

Objections for use as C.S.S. dispensing cart:

a. Designed only to transport trays.

b. Shelf clearance usually inadequate to accommodate the size and shape of supplies issued by C.S.S.

c. Difficult to use for hospital-wide tours because of its design (*i.e.* over-all size and weight) and intended use.

d. Difficult to keep clean because of design.

e. Shelves not provided with upturned rim or bar.

2. Utility truck for linen service and housekeeping.

a. Designed to transport linen and housekeeping equipment. Much wasted space for central supply use because of shelving arrangement.

b. Heavy, therefore hard to handle.

c. Closed shelves (three sides) means increased weight and serves no useful purpose for C.S.S.

d. Extremely difficult to clean; made of enameled heavy steel plate.

e. Usually two swivel casters and two rigid casters making it difficult to push by C.S.S. personnel on long tours.

3. Multipurpose cart.

a. Too small; inadequate in size for most hospitals.

As the next step in working toward a cart designed especially for central supply service use, the following requirements were established.

1. It should be technically safe. Allow for the segregation of dry sterile supplies from solutions as well as the segregation of contaminated or used supplies from sterile or unused supplies.

2. It should be of such proportions and design that it will accommodate all supplies and equipment dispensed by C.S.S. Supplies will vary in size and quantity from one hospital to another depending upon: (a) size of hospital; (b) services rendered by the hospital; (c) functions performed by C.S.S., and (d) technics used to prepare supplies.

3. It should be easy to handle insofar as height, width and weight are concerned. Inasmuch as the C.S.S. delivery service is usually performed by a woman and the cart is heavily loaded, particularly at the start of the tour, it is imperative that the cart be made as easy as possible to maneuver.

Specifications were prepared as follows for a cart to meet the needs of a hospital of 300 or more beds, the foregoing requirements being kept in mind.

Dimensions:

Height 51 inches (from floor to top shelf).

Length 50 inches (from edge of shelf to edge of shelf).

Width 22 inches (from edge to edge).

Specifications:

1. *Material:* Stainless steel.

2. *Wheels:* 6 inches in diameter with rubber tires. Rear wheels to be swivel.

3. *Shelves:* Total shelves, 5. First and third shelves from bottom to have 13 inches clearance. Second and fourth from bottom to have 8½ inches clearance. All shelves except top to have ¼ inch lip on all four sides. Two bars starting 2 inches up from shelf, 2½ inches apart on both ends and one side. Bottom shelf 8 inches from floor. Top shelf to have 2 inch guard rail on all four sides.

4. *Handle to push and guide cart:* A handle on one end, 40 inches from the floor, across the width of the cart.

5. *Clipboard to hold requisition slips:* Resting on handle.

6. *Two hooks to hang bags of supplies:* Place on opposite end of cart from handle, one at each corner. *General specifications:* Hooks to lock in two positions at 90° angle to cart and flat against cart.

7. *Rubber bumpers* for protection on all four corners.

The reasons for these specifications are:

1. The height should not exceed 51 inches so operator can see over the loaded cart during transit.

2. The length should not exceed 50 inches for ease in handling.

3. The width should not exceed 22 inches to allow for easy reaching of all supplies on shelves.

4. The lips on all sides and the guard rails on three sides are preventive measures to keep supplies from falling off cart.

The bottom shelf is intended for used equipment of all sizes. The third shelf with 13 inch clearance is intended for solutions. The second, fourth and fifth shelves are intended for dressings, treatment trays, I.V. sets, gloves, syringes, needles and other such supplies.

The suggested design was submitted to one of the cooperating manufacturers. This is shown in the accompanying sketch.

TO BE FURTHER MODIFIED

Meetings with the manufacturer and further study of the problem by the company research department resulted in the production of a sample cart for trial purposes. The new cart has been in constant use in the hospital which initiated the request for a period of several months. This has led to some suggestions for modifying the design of the cart as it was built.

The over-all evaluation indicates considerable satisfaction on the part

of hospital personnel using the equipment. It is meeting a real need.

OTHER STUDIES

In a 100 bed hospital, the Armstrong County Memorial Hospital in Kittanning, Pa., help was provided in the analysis and revision of the central supply service. Improvements included a new layout for the department; installation of new mechanized equipment for the processing of gloves, needles and syringes; new lighting fixtures to raise the lighting level; improved sterilizing procedures, and new work place layouts for the tasks performed in the department.

Direct help was given also in the selection of operating room instruments for the newest hospital to be built in the Pittsburgh area, the St. Clair Memorial Hospital.

This type of aid has done much to ensure the high standard of patient care which is being sought, as well as to achieve direct savings in nursing time and in the cost of performing the work of central supply service.

IMPLICATIONS AND CONCLUSION

Possible applications of scientific management to nursing service in the operating rooms seem almost unlimited. The highly repetitive nature of the work involved in this department makes it especially suitable for the profitable application of methods improvement principles and technics, the primary objective of this study.

1. *Patient care* is being extended by simplifying the tasks. The improved method of handling instruments, for example, reduces time required for this routine task and makes more professional nursing time available.

2. *Personnel relations* are being improved in a variety of ways. For example, the improved nurses' table layout permits more continuous service during the operative procedure. This leads to improved surgeon-nurse relationship.

Improved work patterns, the substitution of modern functional equipment for older difficult-to-use equipment, and the elimination of unnecessary work all tend to raise morale and increase job satisfaction. Improvements in glove handling are a case in point.

3. *Reduced costs* follow naturally from the foregoing. Specific examples can be seen in the processing of instruments and gloves, and in reduced inventory investment resulting from the room setup studies.

Interest in methods improvement in hospitals is increasing at an ever mounting rate. Much of this is due to the demonstrated results which are being reported upon at hospital meetings and through hospital literature. This is a desirable trend and one that will aid in furthering the objectives noted above.

While for the most part the principles and technics are relatively simple to understand, their effective use requires skilled guidance and specific training. Help in this direction is available from a variety of sources. These need to be utilized more fully.

New York State Hospital Association Adopts Principles for Better Nursing Care

ALBANY, N.Y. — Nursing education cannot and should not be divorced from hospitals, the Hospital Association of New York State declared here last month in a statement of "Principles for the Promotion of Better Nursing Care" adopted by the association.

The principles were released by Dr. Thomas Hale Jr., president of the association and director of the Albany Hospital.

"Nursing education does not belong exclusively in the 'stream of general education,'" the principles stated, replying to a concept that has been heard frequently in professional nursing circles in recent years. "It cannot and should not be divorced from hospitals. The bedside of the patient is the best place a student can learn nursing skills."

THREE LEVELS OF NURSING

The principles acknowledge the need for three levels of nursing, in these approximate ratios: licensed practical nurses, 45 per cent; registered diploma nurses, 45 per cent; registered degree nurses, 10 per cent.

There is a serious shortage of nurses in all three categories, the association statement indicated, and recruitment efforts and attempts to obtain financial support must be directed toward all three types of program.

"Practical nurse schools can be sponsored by high schools or by hospitals," the statement continued. "There is no reason practical nurse students cannot receive their preparation side by side with students in the diploma or degree programs in the same hospital.

"Practical nurses, under proper supervision, can effectively handle a large portion of the basic nursing care in the hospital for which they have been trained."

The statement defines the function of the diploma nurse as giving treatments and medications, acting as a team leader with practical nurses, student nurses and nurse attendants, and taking charge of wards as assistant head nurse and head nurse.

"They do not need a college background," the association statement said of the diploma nurses. "Some colleges are now offering job relations training courses on an extension basis, and this should be encouraged."

The degree nurse with postgraduate clinical experience can best fill teaching and administrative positions in schools of nursing and supervisory positions in nursing service, the association stated.

"Consideration should be given immediately to the development of a shortened curriculum with emphasis on practice and application of theory, rather than theory," the statement concluded. "Some form of progression should be developed in the field of nursing education so that a nurse wishing to advance from one category to another could receive some credit for the preparation she has already obtained without having to start all over again.

"In a well organized diploma program intelligent nursing care is achieved by the student nurse's having a thorough knowledge of basic principles in all clinical areas. This, combined with adequate supervision and direction at the bedside or in a specialized area, will provide a true learning situation which eventually will result in optimum care of the patient.

"Rapid changes and technicalities developing in patient care make this mandatory. Only by a thorough understanding of principles can these constant adjustments be made, thereby ensuring nursing for the future."

These Signs Point to Trouble

Systematic records serve as warning signals to the administration that there are weak spots in the organization that should be corrected

EDWARD H. HEYD

AN ABLE training director for a well known public utility was describing his company's training programs. He pointed out that the training programs were all custom-made to meet specified conditions. They were applicable to all phases of the company's activities—to customer relations problems, accounting, maintenance, warehousing, safety and other phases of company operations. In the discussion he described a few of the indices used by his company to measure or determine weaknesses that needed correction or review. These indices were used as danger signals—red lights, warning that things were not going as planned or desired.

HOSPITALS HAVE INDICES, TOO

We in the hospital field have access to the same indices. They do not necessarily have to be used in conjunction with training. Systematically recorded information can serve the same purpose in hospitals as in industry, identifying weak spots in organizational activity. It can be a danger signal warning that operations are not following the planned scheme, serving notice that we ought to take another look and do something to correct the condition.

The use of indices described here is limited to an appraisal of the effectiveness and success of management, administration, or supervision—the directing forces in getting the job done. This paper will be pointed toward the higher echelons in the hospital organization, the people who have access to indices of various types, and, most important, those who have these records at hand for routine use.

In a hospital, or in any service organization, the personal equation is much more important than in other types of enterprise. It is especially important that the team of administrator and department heads work continually toward common goals. The countless relationships—many of them of an intangible nature—in the area of administrative-supervisory responsibilities are familiar to hospital people, who also understand the desirability in day-to-day routines of reducing intangibles to as many tangibles as possible and using impersonal rather than personal methods. Proper indices can be used to help accomplish this transposition from the unsubstantial to the material; they can establish measuring devices for month-to-month evaluation of activities; they can illustrate the development of trends, and they can be a reliable, impersonal denominator, strengthening administrator-department head relationships in constructive and objective planning.

It is unlikely that any one index can be a reliable indicator. Several related indices, however, can usually point to a weakness and provide substantial evidence for consideration. When the danger signals are augmented by the administrator's intuition and experience, the area of weakness is defined more readily and precise action can be taken. It is essential to recognize the inadequacy of using only indices or records to measure performance. They are valuable guides, but they cannot be used to supplant personal knowledge. Records and reports can never be a substitute for personal rounds or for individual observation and study. A cardinal rule of military service, proved over a long period of time, is that personal, on-the-spot knowledge is essential. It is just as unsatisfactory, however, to guide the destiny of an organization by no other recourse except personal observation, to make all decisions off the top of one's head. Factual management tools should supplement the know-how of experience.

FINANCIAL REPORT USEFUL

The monthly financial operating report, for example, especially when based on a budget, is a good index of the hospital's operation. It has unlimited utility as a measuring standard. In the careful preparation of a budget, estimates of operations have been made. Intelligent and logical thinking has predicted specific items of income and expense, either on the basis of past performance, or by other calculations. A pattern has been formulated, and certain courses of action are thus anticipated for each component of the organization

The forecast is particularly reliable when those using it as an index have participated in its compilation and share in its execution. One is not compelled to meet the budget forecasts; rather, the budget serves as a guide to the achievement of predetermined performances. From the administrative point of view, it is just as important to look at figures that fall below budget estimates as it is to scrutinize those over the budget. In other words, variations over and under allowable budget limits are danger signals,

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Condensed from a paper presented at the Ohio Hospital Association Institute on Business Management, Columbus, November 1955.

Mr. Heyd is administrator of Children's Hospital, Cincinnati.

warnings to look further. Mutual understanding of budget and operating statement by departments and administration does not attribute variations to chance or assumption. Casual explanations are not accepted. Instead, detailed study leads to better comprehension by all parties of factors that have come to light in the operating report or record.

SAFETY RECORDS

Another index available to all of us is the employe safety record. A good worker is a safe worker; a good supervisor is a safe supervisor. The good supervisor is safety conscious. He has built safe operating practices into each job he supervises, and he is constantly alert to unsafe conditions. Safety cannot be applied as something extra to the job, like icing on a cake. Safe operating practices and conditions are inherent in doing the job properly. In our hospital the recording on an accident form of major and minor injuries and an analysis of their cause are valuable indices. In addition to the necessary personal information and the pertinent medical history, an accident report should include (1) exact location and place of accident and (2) a description in detail of how the accident happened.

The routing of the accident form from the personnel physician through the administrator, the interested department head, the chairman of the safety committee, and the personnel officer is effective. The enlightenment gained by such routing is obvious. Our personnel officer compiles the detailed Ohio Hospital Association quarterly accident analysis statement from the hospital's accident reports. This statement is circulated to all department heads and other interested parties.

A review of the descriptions of accidents emphasizes that unsafe practices are generally the result of individual carelessness or failure of supervision. Human failures outweigh unsafe mechanical conditions. Many accidents can be avoided if the supervisor is on the job. It is interesting to study the departments having the most accidents, to look at the nature of the accidents, and note which employes are being injured. In this instance, we have a tangible index to the effectiveness of our over-all supervisory strength and competence in the area of safety—the premium for workmen's compensation insurance.

A report of patients' accidents is an index to another perspective of hospital operation. It is hard to overemphasize the importance of good supervision to avoid such accidents as administering the wrong medication, not following specific treatment orders, and falls from bed. Unfortunately, errors in treatment and medication will undoubtedly be with us as long as we have hospitals. We all have established routine procedures to keep the chance of error to the minimum. To the best of our abilities, we supplement these routines with close supervision, recognizing that without the latter even the best plan is useless. Despite all we do, there are still some pertinent questions which can be asked. Why do accidents happen oftener on some floors than others? Why do accidents occur sporadically? Why do accidents stop when more attention is given to supervising routines? We all recognize differences among individuals. However, when records of accidents are reviewed objectively and hazards are emphasized, there is always a strengthening of supervision and consequent reduction or elimination of the accident problem.

Studies have been made which scientifically support the relationship between certain employe characteristics or behavior and effective supervision. Probably all of us are familiar from past experience with these characteristics, but we have not necessarily systemized them in our thinking so that they may be used as constructively as they might be.

What are these indices? A few records, especially, are significant and can be reviewed advantageously. These are:

1. Absenteeism, especially before and after holidays, following a day off, after pay day.
2. Excessive time off.
3. Tardiness, periodic or frequent.
4. Excessive sick leave, especially after holidays or pay days.

These simple, but basic employe characteristics usually are not found in the same ratio in all departments, although employes may be drawn from comparable social and economic levels and screened by one personnel officer. The difference can be found in the fundamental trait—job interest. The development of job interest is a fundamental responsibility of supervision. Using these records as indices may throw light on the success supervisors are having in creating job interest among employes and, as a primary by-product, show the effectiveness of planning and scheduling work.

There are several other personnel indices having to do with labor turnover. Let us forget additions to the payroll for the moment and think only in terms of separations. We would have no worries about the former if the latter didn't exist. All of us have known the department that "just couldn't get good people." Such a department would not have to get any people if it could hold the people it has.

EXIT INTERVIEWS

Separations can be divided roughly into two classes—quits and discharges. Why is it that one department always arranges an exit interview for its people who are quitting, while another department reports that employes just didn't come back to work; they left without notice. Why is it that one department may show a number of reasons for separations, *i.e.* getting married, having a baby, moving out of town, getting a better job, caring for someone sick at home—which are substantially verified by exit interviews or by investigation, whereas another department always says, "good riddance," or gives some incriminating reason for every separation?

Many times *the ratio of exit interviews to the number of separations* is a more reliable index of employe satisfaction than the reasons given for leaving. There is obviously something wrong when a department has an exorbitant discharge rate as compared to another department requiring the same type of personnel. A good supervisor will have to discharge an employe occasionally, of course, but it is not

"Part-time work has a way of growing in some departments"

necessary to set a record for discharges. An evaluation of separations, both quits and discharges, offers a good, objective yardstick of supervisory performance.

NUMBER OF TRANSFERS

Another index is the number of employes seeking to leave a department and the number of transfers into the department. All of us know of certain departments to which no one wants to transfer. Often such an undesirable location also has a high discharge or quit rate. Another aspect of the transfer record that should be studied carefully identifies the departments that offer cooperation to make good employes available for the rest of the organization. The transfer index is tricky; it cannot be used alone, but when related to other records it may help reveal definite trends in employe satisfaction and the effectiveness of supervision.

Other interesting indices are the records for overtime and part-time employes. Overtime that is planned is almost always overshadowed by "emergency overtime." A reliable characteristic of planned overtime is that it is not usually reported in fractions of an hour. Good supervision, it seems, will always find some way to avoid the 30 minute or 45 minute or even one hour overtime period. I do not mean that overtime is not justified on occasions. Overtime in accounting may be in order every month to meet a deadline for getting the statement to the board. This is generally a planned activity to meet a specific time requirement. However, it is difficult to justify sporadic overtime occurring continually in the same department—and many times involving the same individuals.

With facts on overtime in hand, the administrator and department head can confer with the goal of more exact planning and scheduling by supervisors or a rearrangement of work schedules to provide more efficient operation. The overtime record may bring unknown causes to light, or it may clearly show up a serious operating problem that requires immediate correction. Few of us allow for overtime in our routine planning; all of us anticipate overtime in a genuine emergency. However, by proper planning emergencies can be anticipated to a large extent and accommodated as routine operating procedures. Frequent emergencies or crises certainly point to poor planning, which is the responsibility of the supervisory or administrative staffs.

The part-time job record is another index that warrants consideration. Part-time work in some departments has a way of growing, both in number of jobs and number of working hours. There is likely to be more careful planning put into the full-time job; the part-time job is seldom planned in as much detail. The number of hours of part-time work thus merits some thought and consideration. There undoubtedly will be some work which can best be done on a part-time basis. Such jobs can be scheduled for the mutual benefit of the employe and the institution. However, there are other part-time jobs whose days and hours are irregular and pretty much at the discretion of the employe. A look at this type of record in the light of the institution's need and the work schedule is clearly indicated.

A parallel index involves the use of volunteers. The number of hours and kinds of jobs performed by volunteers also provide a useful guide for management. We should try to evaluate this information—the hours and the jobs—on the same basis as part-time employment and overtime. These records are enlightening for administrative and departmental consideration of the institution's work requirements, the effectiveness of supervision, and the economics of institutional operations.

Still another index that reveals useful facts about our operation, the effectiveness of our supervision, and the thinking of our employes is the lowly requisition. Again, some departments or areas of the hospital apparently must live in an atmosphere of emergency to stay in business. There are emergency orders to the storeroom for a can of peaches, emergency orders to the linen room for blankets, emergency orders to pharmacy for aspirin, emergency errands to the laboratory, to x-ray, and to dietary. All this activity is carried on in an aura of crisis.

Other departments have emergencies —the occasional true emergency—but somehow the supervisors in these departments, whether by anticipating the emergency or by intuition, seem to have plans in mind to meet emergencies with a minimum of confusion. An emergency doesn't come as a surprise, finding the organization flat-footed without preparation or forethought. The best supervisory planning anticipates the unusual by having a course of action ready. A review of the causes for time consuming emergency requisitions will give evidence of the need for more planning by the directing staff.

INVESTIGATE EMERGENCIES

A factual investigation that would correlate recurring emergency requisitions and the volume of supplies requisitioned routinely would be interesting. In many instances, the greatest number of emergencies and the heaviest requisitions for supplies would probably occur in the same departments. Several administrators have indicated they have records to substantiate this correlation.

Furthermore, I believe investigation would reveal that the supervisor who has trouble working within prescribed linen standards is the same supervisor who also encounters difficulty operating within other standards—even capital expenditure items or nonconsumable goods, such as emesis or wash basins, ophthalmoscopes, bandage scissors and water buckets. This is not a new idea. We know families that make a little go far, and we have some of the same type of persons working in our hospitals—as well as others with traits that are exactly opposite.

Since these people are our employes, and since we must answer for their conduct, do we not have a responsibility to inform them of this characteristic? It is difficult to convince such an offender, unless we can produce the facts in a record or index showing the variations from standards, in all the different areas of control.

(*Continued on Page* 80)

"Shop orders may point to a letdown in supervision"

In the control of supplies, too, we should think not only of the items consumed, but also of the unused inventory carried on shelves, secreted in closets, or in some instances carefully inventoried for all to envy. The cost of this kind of lavishness may be considerable when multiplied by the number of persons having these same tendencies.

SHOP ORDERS

Another type of requisition that may be a good index of weakness is the shop order for maintenance repairs. In our hospital, we have ground rules that stipulate the occupying department has full responsibility for the area it occupies. For example, the ward areas occupied by nursing are under the full supervision of the head nurse. Maintenance has set up a preventive program that takes care of as many routine repairs as possible, such as water valves, motors, electrical equipment and sterilizing equipment, but it is the head nurse's responsibility to submit shop orders for other repairs in her area.

Some shop orders point to a letdown in supervision. Stopped-up lavatories, for example, are avoidable if supervisors stress the proper use of this equipment. The clogged incinerator jammed with papers, boxes, cans and bottles is just as inexcusable. The burned-out bulb that has not been replaced indicates someone is not doing his job. Why is a bed returned to the shop for repairs with only three casters? If a nurse or maid stands in the middle of the room and whips an extension cord, sooner or later the cord will come loose, but the plug will remain in the receptacle!

The nuisance of mopping and subsequent replacement of loose tile can be avoided if the container for melted ice in the oxygen tank is emptied systematically. It is expected that a flowmeter or oxygen gauge will be dropped occasionally, but it is incomprehensible how the case can be damaged beyond repair and the inner works spilled all over! In our hospital we expect to find an occasional toy, or perhaps a piece of hospital equipment, in a humidifier, but it is puzzling to find the orifice looking something like a Christmas stocking!

These are examples of the type of repair requests that indicate lack of care and, in turn, show that administration and supervision should heed the danger signals. These abuses may be localized by department or area as well as by people. One maintenance supervisor, for example, after surveying his repair requests, came to the conclusion that the majority of the destruction was done over week ends. On week ends, particularly with the 40 hour week and the lower week-end census, many hospitals have fewer supervisors on duty than during the week. In any case, it is evident that a major portion of repair requests could be eliminated by closer supervision.

The time factor is also of interest in connection with shop orders. As in requisitioning supplies, it appears that some departments operate on an emergency basis for repairs. Almost all requests for maintenance service are emergencies—reportedly necessary for good patient care.

It is obvious that the character of shop orders has a relationship to supervision and administration. If chaos ensues whenever something out of the ordinary comes up, the hospital or department will be living from crisis to crisis. On the other hand, if the organization is capably administered and supervised and there is some preparation to meet difficult situations, most sudden and unusual occurrences can be handled in stride.

Finally, shop orders may be studied as a means of measuring the extent and success of the preventive maintenance program. If there are too many shop orders requesting work that can be covered by routine preventive maintenance inspection, there must be something wrong in maintenance. By this procedure, maintenance can readily review the results of its contribution, and then adopt a plan which will make its own work more effective.

The summary of telephone switchboard service prepared by the local telephone company is another significant record or index for the administrator. It points out the competency of the telephone operators and, in addition, indicates how operating technics and courtesies are being used.

Let us look at this report first as an evaluation of our telephone operators. Good switchboard service requires the operator to speak immediately after making a connection, eliminating the irritating silence from the time the ringing signal stops until the operator speaks. Good service also requires that the caller should not have to wait more than 20 seconds from the time the number is first rung until the operator answers the call. Another factor in the skill of the operators is their manner of replying to the caller's request. The operator should repeat or acknowledge the request, showing that she understands what is wanted. She should also check back periodically with a caller waiting to complete a connection.

The basic requirements also include accurate service, no cutoffs, and no connections to wrong or busy extensions. All these fundamental operating requirements are measured on a standard form prepared by the telephone company. Provided the equipment is adequate, this summary is an excellent tool for the supervisor to use in correcting errors made at the switchboard. It is a basis for evaluating telephone service and the necessary training to improve it.

GOOD TELEPHONE MANNERS

The summary can also be used as an index for other than switchboard personnel. It is not only good telephone manners but gives an impression of being on the job when the station and person receiving a call are identified. An impersonal "hello" necessitating inquiries to ascertain who is speaking is a time-waster and in the final analysis is discourteous. A significant item the survey records is the promptness of answers by extension users. This is very important to management. There are several essential stations in a hospital that should be staffed 24 hours a day, 365 days a year. People within the institution and outside expect to talk to someone in these areas: admin-

istration, nursing office, maintenance, admitting and others. When the telephones at these stations are not manned, we may expect trouble.

During working hours, one should expect an answer at all stations. The mechanics are not too difficult to manage if lunch periods are staggered, working schedules are rearranged, and calls are properly rerouted or transferred. It is a problem, however, to impress personnel with the importance of good telephone service.

The telephone summary is factual. It is based on the actual performance of telephone users. It is wholly impersonal, reported by an employe of the telephone company. The results in the hospital may be compared to a tested rating scale. Since the telephone is an extremely important instrument in our communications system, this report is a valuable index to operating efficiency.

INVENTORY SPOT-CHECK

Another factual report is the weekly inventory spot-check. Supplies are maintained on perpetual inventory and disbursed from central stores on requisition. Each week the office manager, who has no responsibility for stores except recording inventory figures, takes 10 commodity cards at random from the master inventory file in the storeroom. He writes the items on a form which is given to the storekeeper. The office manager retains the cards while the storekeeper records the actual bin count on the form. The form is then returned to the office manager, who reconciles the figures on the perpetual inventory cards with the new count.

This index provides a number of worth-while management measures—spot-check reports of inventories, movement of inventories, errors in stores records, late posting of stores records, among others.

In our hospital we maintain lists, by locations, of such items as ophthalmoscopes, otoscopes, laryngoscopes, and other larger equipment. We do not believe it desirable to lock this equipment up, and yet there is the tendency for it to disappear unless some controls are exercised. Regular daily or weekly checking has not been considered feasible. We believed an irregular inventory would better serve our purpose. It has been standard practice that each department should take its own inventory, to avoid the attitude that inventories may be a police action.

There is also a basic philosophy of operation that enters into this picture. Is all equipment to be counted daily—checked as narcotics are? Is it to be under lock when not in use? How much valuable time can supervisors spend making inventory reports? We believe the irregular inventory, with recognition that some areas are more vulnerable to loss or abuse of equipment than others, supplemented by indoctrination of supervisors as to the importance and desirability of our practice, is the best plan. The inventory serves as a reminder of accountability.

Inventory reports from central supply provide a better insight into nursing unit operations than any other reports. It is interesting to note which floors have the greatest losses of equipment. It is interesting, too, to study the nature of the losses, though these are no different than one might expect. We lose scissors, but we seldom lose stainless steel trays or cups, though we had to discontinue the use of stainless steel medicine cups because they had so many other useful purposes. These records, however, do serve as an index of the effectiveness of supervision.

Here are a few brief comments on some other indices we have used with good results:

The number of complaints and commendations may be a guide to public relations needs.

The narcotic and barbiturate report has possibilities when related to other indices; waste, loss, order of inventory, and ease of record taking are the important considerations.

Accounts receivable and accounts payable may reveal the over-all efficiency of the various groups concerned with these matters. Admitting, credit and collection and cashiering operations all play their part in the status of receivables, and, in turn, purchasing, receiving and stores play a part in payables.

Numerous other logs and inspection reports contribute valuable information to administration and supervision: condition and operation of elevators, autoclaves and automobiles; fire inspection, safety inspection, and others. These appraisals or measurements, for the most part, are not absolute. They have a relative value when used logically. They offer a systematic procedure for evaluating a human factor that is difficult to appraise—*the effectiveness of supervision.* There is no question that good supervision is the basis for a good hospital operation.

PROBLEM IS COMPLEX

In the hospital field, where results are not measured on a profit and loss basis, our problem differs from that of most business organizations. In addition, we have professional and highly skilled personnel; the emphasis is on scientific and technical ability and knowledge rather than supervisory skill. A good chemist does not necessarily qualify as a good directing head of the clinical laboratory, nor is the skilled dietitian necessarily suited to administer a fast-moving employe cafeteria. There has been little attention given to the formal development of supervisory skills in hospital people, prior to their employment in hospitals, and we have not provided supervisory training comparable to industry. For most of our personnel, it has been a case of trial and error.

How can we rectify this condition? I believe the use of indices offers an objective and effective means of working with our supervisory staffs. An index provides us with something that is reasonably substantial, and which definitely reflects the results of our operations. It is not the perfect system, but it is flexible and can be developed. Above all, it gives us something that is not just for the front office to think about or to be filed in the archives. It provides a tool which may be used to encourage participation by the supervisory staff in our mutual problems.

ABOUT PEOPLE

Administrators


Ernest L. Bliss

Ernest L. Bliss has been appointed administrator-consultant of Suburban Center Hospital, Cleveland, which will be under construction some time this spring. Most recently, Mr. Bliss was administrator of the Jackson-Madison County General Hospital, Jackson, Tenn. He has also served as staff consultant to James A. Hamilton & Associates, University of Minnesota; as director of Eye, Ear, Nose and Throat Hospital, New Orleans, and has been a member of the medical administrative staff of Standard Oil of New Jersey. Mr. Bliss is a graduate of the University of Chicago course in hospital administration and a member of the American College of Hospital Administrators.

Louis Drexler, formerly assistant to the superintendent of Bergen Pines County Hospital, Paramus, N.J., has assumed his duties as administrator of the Charles Choate Memorial Hospital, Woburn, Mass. Mr. Drexler has been associated with the New York State Department of Public Health and has served as assistant to the managing director of the National Tuberculosis Association in New York.


Dr. S. K. Djazzar

Dr. Sabih K. Djazzar is now director of Damascus Hospital, Damascus, Syria. Dr. Djazzar received a master's degree in hospital administration from Northwestern University, serving his residency at University Hospital, Ann Arbor, Mich. He also holds a master's degree in public health. Under a Ford Foundation grant, Dr. Djazzar visited hospitals in the 48 states, before leaving this country last September.

Clarence R. Wagner has assumed his duties as superintendent of Claremont Manor, Claremont, Calif.

Dr. Cecil G. Sheps, executive director of Beth Israel Hospital, Boston, has been appointed special consultant to the new hospital facilities research study section of the Public Health Service. Dr. Sheps' appointment is for a period of three years.

Earle S. Wilks, administrator of Adams County Hospital, West Union, Ohio, has been appointed administrator of McCullough-Hyde Memorial Hospital, which is now under construction at Oxford, Ohio.

Howard R. Jones, assistant superintendent at Municipal Hospital and Health Center, Hartford, Conn., has been named administrator of Memorial Hospital, Logansport, Ind. Mr. Jones is a graduate of the University of Minnesota program of hospital administration, and served his residency at Good Samaritan Hospital, Portland, Ore. In 1950-51, he was organization and methods examiner for the administrative management branch of the Bureau of Medicine and Surgery in the Navy Department at Washington, D.C. Mr. Jones succeeds **William W. Turner,** who is now assistant administrator of Seaside Memorial Hospital, Long Beach, Calif.


F. E. Krizman

Frederick E. Krizman has been named assistant superintendent of the Polyclinic Hospital, Cleveland. For the last eight years, Mr. Krizman has been business manager at St. Ann Hospital, Cleveland. Mr. Krizman is a personal member of the American Hospital Association and president of the northeastern chapter of the American Association of Hospital Accountants.

G. Paul Hanson has been appointed assistant superintendent of Cedars of Lebanon Hospital, Los Angeles. Mr. Hanson was formerly assistant administrator of Franklin Hospital, San Francisco. He is a senior member of the American Association of Hospital Accountants.

Dr. Endre K. Brunner, manager of the Veterans Administration Hospital at Manchester, N.H., has been appointed manager of the V.A. Hospital, Bronx, N.Y. Dr. Brunner succeeds **Dr. John G. Hood,** who recently was named area medical director at the Veterans Administration headquarters in Columbus, Ohio.

Dr. George L. Wadsworth has been appointed superintendent of the Anoka State Hospital, Anoka, Minn. Dr. Wadsworth was formerly manager of the Veterans Administration Hospital in Roseburg, Ore. He succeeds **Dr. John H. Reitmann,** who has resigned to take further psychiatric training.

Fred J. Bommer, formerly assistant administrator of the Valley Baptist Hospital, Harlingen, Tex., is now administrator of the Montgomery County Hospital, Conroe, Tex.


John W. Kludt

John W. Kludt has been appointed administrator of Lillian Collins Hospital, Turlock, Calif. Mr. Kludt was formerly assistant administrator at Sequoia Hospital, Redwood City, where he also served his administrative residency. He is a graduate of the University of California's course in hospital administration.

Sister Holy Heart of Mary is now administrator of Misericordia Hospital, Milwaukee. Prior to her new appointment, she had been administrator of St. Joseph's Sanatorium, Montreal, Que. She has also served as administrator in Sisters of Misericorde hospitals in New York and Canada.


Bernard McCarthy

Bernard McCarthy has been appointed administrative assistant in charge of outpatient service at Pennsylvania Hospital, Philadelphia. Mr. McCarthy is a graduate of the University of Toronto school of hospital administration and served his administrative residency at Toronto East General and Orthopedic Hospital.

Dolores Haugland has resigned as administrator of Redwood Falls Hospital, Redwood Falls, Minn.

Richard C. Luttrell, formerly business manager at Hillcrest Memorial Hospital, Waco, Tex., is now administrator at Norman Municipal Hospital, Norman, Okla.

(*Continued on Page* 179)

Somebody Has to Pay for Patient Care

There is no such thing as a "free bed" and it's up to hospitals to make not only the public but their own trustees and staff understand the need for adequate payments for all patients, including the indigent

A MODERN HOSPITAL ROUND TABLE

IN THE second and concluding section of the round table on the need for more businesslike methods in hospitals, the experts point out that it's time to stop saying that "hospitals are different" to explain away laxity in administration. Taking part in the discussion were: Arthur Hibson, accountant and director of the Hospital Fact Finding Service at Clinton, Conn.; Robert Jones, administrator of Waukesha Memorial Hospital, Waukesha, Wis.; Harry Humbert, comptroller, Johns Hopkins Hospital, Baltimore; C. Rufus Rorem, executive director of the Hospital Council of Philadelphia, and Mortimer Zimmerman, executive director of the Louis Weiss Memorial Hospital, Chicago. Everett W. Jones, vice president of the Modern Hospital Publishing Company, acted as moderator for the group. A recording of the discussion was made and is presented here, edited only to eliminate repetition and irrelevancies.

MR. E. JONES: One of the greatest problems hospitals have is to get the necessary working capital—cash in hand—to allow us to extend credit to patients. It's easier for business to dig up working capital because it has potential profits. The hospital has no potential profits, and it is therefore a much worse bank risk, so our problem of getting working capital is quite different from business. As an example, too many hospitals actually get their working capital from suppliers, by not paying their suppliers over long periods of time. The hospital has extended the suppliers' money, in reality, to the patients who couldn't pay.

MR. HUMBERT: I can recall back in the 1930's when a lot of industries were getting working capital on the same basis!

MR. ZIMMERMAN: Some of the mail order houses today extend credit to people, often without checking in advance, and they have the same kind of collection problem that we have. They often get their working capital in just that manner. They don't pay their bills for 60 or 90 days, and their suppliers go along with them because they know what their problems are.

MR. E. JONES: In some of those cases, however, the business houses can repossess, take the goods back for some value, whereas the hospital has nothing to repossess. And it's not uncommon for a hospital to let its suppliers go six months, or even longer. No supplier selling a mail order house is going to extend any such credit as that. Actually, if trustees only understood it, a hospital has to have *more* working capital to finance credit than most business houses.

MR. HIBSON: Businesses are normally financed by owners. Somebody puts money into a business and owns it; that's essentially the basis of the working capital of a business. A hospital must finance its working capital out of the only sources available to it —its operating revenue or donations. If the patients don't pay, our accounts receivable go up and we must get the money to carry those accounts receivable from the same source—in other words, our gross income.

DR. REMEM: If I understand the discussion, what we have said is that hospitals may or may not be as efficient and as zealous in the collecting of individual accounts as business enterprises. That is not the point. The point is that up till now most institutions have not made a thorough enough analysis of their total accounts receivable so that they can direct their efforts into the most rewarding channels, and, too, that a part of the list of receivables might reasonably be expected to increase their collections. I think that's a good point.

MR. HIBSON: I would like to go one step further and suggest a research study of patients, so we could check off certain characteristics of patients that would alert us to the potential poor-paying patient. For instance, a storekeeper is a poor-paying patient; that I know from my own experience. There are other, similar characteristics. By a study of the knowledge we have of patients we could earmark the characteristics that our admitting officers and credit officers should be alerted for. If we did that we would see that many of our patients don't need the kind of stimulus we're giving them and that we're hitting the good patient over the head as well as the bad patient.

MR. E. JONES: I suppose this is the difference between business and the

hospital: Business doesn't have to worry about enlisting the aid of an independent group on its credit problems; it just doesn't sell if the credit isn't good, whereas we sell many, many times knowing that we have a bad credit risk.

DR. OREM: This discussion now is leading back to the character of the hospital as a social institution. This raises the question of whether the collection for a commodity which you sell against your will, and which the patient receives against his wish, can ever be handled by methods that are the same as those used for private commodities. From the administrative point of view the account receivable of a man who is unwilling to pay is different from the one who is unable to pay, and still different from one which is legally pending, such as an insurance carrier, and different again from some situation where an agency or an individual may be contesting the bill. If those were broken down so that they can be analyzed separately, shotgun methods wouldn't be applied to all, but individual methods would be developed to suit the situation.

COLLECTION METHOD IS DIFFERENT

MR. HUMBERT: I think our method of approaching the collection of accounts *is* different from industry's. When I was in the petroleum industry we were selling fuel and gasoline. If the account wasn't paid, we would put it on a load-to-load basis. The customer had to pay for the first load before he got the second one. In the hotel field we didn't play with the guest; if he didn't pay his bill, we had recourse to the law and the defaulter would end up in jail. In the hospital field we have something different. We have the account forced on us, so we change our method of collecting. Because we are a social agency, we can't force the man to pay unless we know he *can* pay. If a man receives medical care and can't pay, there's not much sense in trying to force him to pay.

MR. E. JONES: Many hospitals could profit by a closer look at every account to see whether it is a legitimate charity write-off or an account that they can and should take legal action to collect. The facts that most hospitals keep on these accounts are not sufficient; in most cases, hospitals don't make enough investigation to find out whether they're dealing with a legitimate charity or just a fellow that's hard to collect from.

MR. HIBSON: Yes. We tend so to generalities; we never have those basic facts; we never look them up. Business is different; everybody in the business organization has a responsibility for keeping departmental records, and in addition, there are the general accounting records. We have no so-called cost accounting in hospitals; we have a so-called cost analysis. In business, you invariably have a separate program of cost analysis for every department. We have no parallel method in hospitals. That comes from the profit motive in business as against the professional motive in hospitals, because we have excellent records of control over our professional goals but we have practically no departmental records over our financial goals. We need systems and methods that will furnish these. I go into small hospitals and they have exactly what the American Hospital Association has told them in its manual of accounts—it's surprising how identical systems of accounting in hospitals are becoming! The hospitals are simply doing a mechanical job. Something is turned out; it goes to the administrator; the administrator looks at one figure, and he isn't even sure what that one figure means, because the profit and loss statement has no meaning unless you correlate it with the month and the year.

COST FIGURE IS STANDARD

MR. HUMBERT: You said that in industry the individual departments maintain their cost records and know what their costs are. I don't think that's a true statement. In industry the cost figure is usually a standard that has been established. The departments can measure their own results against that standard, but they are still getting the basic information from the financial or accounting divisions. In the sales department, the sales manager can't tell you the cost of managing his department, but he can tell you whether or not he will show a profit on a given account. A transportation company may analyze its accounts and say, "We're not going to call for that man's merchandise any longer; it's not profitable enough for us to handle it."

You look into the hospital field and say the administrator and the accountant don't understand the figures they produce. They're following the A.H.A. classification of accounts mechanically, and the administrator sometimes doesn't understand the figures when he receives them. If that's true, isn't it the fault of the trustee for bringing in inefficient people—people who don't know?

DR. OREM: It seems to me it doesn't make any particular difference whether you calculate costs accurately or not if you don't collect them after you've done so. The problem in hospitals as I see it is not in the unnecessary or frivolous expenses within the institution, but rather in the fact that as a matter of public policy much of the service is inevitably given away, and no corporation that gave away half its products could solve its financial problem by saving on the wrapping paper. The big problem in the typical institution is that the hospital takes on, first, the responsibility of providing a service and, second, the responsibility of getting the institution reimbursed. We have to recognize that all service must ultimately be paid for, and if we give it away with our left hand, we must recapture it with our right hand, or have it come in from some direction. Not only have we been careless, possibly, in collecting from the people whom we charge, but also in establishing policies as to who should be charged, and how much. That goes not only for the individual patient who is broke or financially embarrassed, as are many of the medically indigent, but for third parties with whom contracts are established, such as Blue Cross and commercial carriers and also local governments.

SET RATES HIGH ENOUGH

MR. E. JONES: Here is a vital point. The welfare laws of many states or areas provide that they will pay the hospitals either cost or their lowest published billings, whichever is lower. Now, if the hospital hasn't been foresighted enough to set its lowest published rates, that is the day rates plus the rate for extras, so that these billings bring in approximate costs, it automatically is subsidizing welfare departments or compensation insurance or some other agencies. That is simply lack of administrative know-how.

DR. OREM: Early in the discussion Mr. Jones spoke of receipts from patients, whereas now we are considering payments *on behalf of individual*

(*Continued on Page* 142)

Labor Calls the Shots on Health Service

If labor unions have their way, and they probably will, the prepayment agencies of tomorrow will place far more emphasis on prevention, diagnosis and early treatment

HARRY BECKER

SUPERFICIALLY it would appear that the views of organized labor with respect to health programs are too conflicting to present an orderly picture of the shape of things to come. This is, however, far from the truth, for underlying the policy statements of labor leaders, and the health issues currently being discussed in collective bargaining, there is a consistent pattern and a clearly evident trend. In fact, upon careful analysis the pattern of labor thinking is not only sharply focused but is so uniform throughout organized labor that there is little doubt on the probable course of developments over the next five to 10 years.

MANAGEMENT WATCHES COSTS

Although unions generally initiate employe health benefit programs, the views of management, the party of the second part in labor-management health programs, are going to become increasingly important. Over the next 10 years the views of management, on some issues at least, are going to be of even more importance than those of labor in determining the shape of things to come. Labor is undoubtedly going to focus attention more and more on the character and type of benefits and the general level of protection provided, as well as on expanding the proportion of the cost financed by the employer.

Management, on the other hand, is going to become more and more concerned with the factors that affect the cost of health benefits and on how these factors can be offset by more efficient and effective use of funds. In the future, employers, more than unions, can be expected to ask the providers of health services how costs can be kept as low as possible and still provide the levels of protection set forth in labor-management contracts.

For the purposes of this paper the ideas of some hundred labor leaders in all sections of the country were sought and, for the most part, the contents of this paper are a synthesis of the ideas obtained. It should be remembered, however, that each union has its own way of expressing its thinking and objectives. Also, that the thinking and practice in a well organized international union will generally be more uniform throughout the country than will be true for less well organized international unions. And, of course, the independent unions in a given geographical area will tend to follow a pattern of thinking more or less peculiar to the particular region.

However, the striking fact with respect to health programs is that union leaders, throughout the country, regardless of the size and type of union, are concerned with essentially the same problems and have the same objectives. The shape of things to come in health benefit program planning cannot be viewed only from a local or a regional perspective; realistically the view must be from a national perspective.

Labor-management health benefit programs, on a broad scale, are a relatively recent development. It was not until the close of World War II that the courts recognized health benefits as an item for collective bargaining. Even now, though most labor-management contracts provide health benefits as a condition of employment, labor has yet to establish a national health benefit pattern. National patterns have been established for wage increases and for many other conditions of employment. Throughout industry, for example, private pension plans show far more uniformity and agreement on basic principles than is true for health benefit plans. One reason the labor-management health protection programs have grown in a comparatively disorderly manner and appear, on the whole, to be a hodgepodge, piecemeal picture, is that in no one collective bargaining round, so to speak, has health protection had top priority as a national labor-management bargaining issue.

TOP BARGAINING ISSUE

Within the next five to 10 years, in one or more of the national pattern setting negotiations, health benefits will become a top priority collective bargaining issue. When this occurs all labor-management health programs throughout the country will begin to assume a more uniform pattern than exists today. In many respects it is fortunate that health benefits have not, as yet, been a first priority collective bargaining issue because it has enabled unions and employers, on one hand, and prepayment plans and the providers of services, on the other,

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Presented to the Western Conference of Prepaid Medical Service Plans, Oct. 28, 1955, Seattle. This paper is based on a survey of leadership opinion obtained in the fall of 1955.

Mr. Becker is consultant to Blue Cross plans and a member of the faculty, Northwestern University program in hospital administration.

to experiment with various approaches and to learn many of the problems inherent in prepaid health care programs. However, when health benefits do become a primary collective bargaining issue, an issue around which a major strike could occur, in national pattern setting negotiations, the shape of things to come will depend on how well today's problems are resolved for unions as well as employers.

When we view the prevailing labor-management health benefit programs, we must remember that as far as provisions established in collective bargaining are concerned the over-all picture is, to say the least, extremely fluid with many unanswered questions for all concerned. Neither the benefit structure nor the prepayment mechanism have been as fully formalized as they will be when a "round" of labor-management contract negotiations evolve primarily around the health issue. However, even without a national pattern setting negotiation as an aid in crystallizing principles and in shaping benefit and other concepts, the year-to-year adjustments being made in health benefit programs are pointing in a given and consistent direction.

CONGRESS STUDIES PROGRAM

This winter and next spring, Congress is expected to consider a hospital-medical benefit program for federal government employes and their dependents with the federal government participating in the cost in much the same manner as many private employers do. Congress will undoubtedly consider, just as any employer would, the various alternative approaches which may be feasible. If the many public issues, as well as employer-employe issues, in prepaid health care are fully discussed in congressional hearings, and on the floor of Congress, which is not an unlikely possibility, the program that finally emerges will have a great impact on the shape of things to come in health benefit planning. What is done for federal employes will become a target for employes in private employment and also in state and local government employment. In fact, the federal employes' health benefit program, as finally developed, will very likely become a standard for all gainfully employed persons whether they are self-employed or working for others.

The recent merger of the American Federation of Labor and the Congress of Industrial Organizations will have a profound influence on labor-management health programs. Within the C.I.O., even though specific benefit structures vary widely, in general, a reasonably consistent approach to major aspects of health benefit planning has been maintained because of the pattern setting effect of the major negotiations in the steel, auto and other industries. Characteristically, the A.F.L. unions do not follow the lead of any one employer or union to the same extent that the C.I.O. unions do. Under the new national labor federation, however, with a strong planning and research staff in the field of health benefits, together with the influence of pattern setting national negotiations, the trend will be toward greater uniformity in the union approach to health benefit planning.

Legislation introduced at this next session of Congress on health and welfare funds will result in further hearings and congressional debate on labor-management health programs. Practices not in the public interest, or not in the interest of unions and employers, will be brought into even sharper focus. Relations between employers and insurance companies, and insurance companies and unions, which have resulted in a higher than necessary cost of protection will certainly receive attention and will have an effect on practices not in the employes' best interests. The health and welfare fund concept, which is a commoner approach in some sections of the country than others, will also be reviewed and, as a result, some current practices may be modified. Both unions and employers can be expected to give more attention to health and welfare fund administration as well as to existing relationships with insurance carriers.

It is interesting to observe the various stages through which union health benefit planning passes. Not uncommonly, when a union first begins to negotiate for health benefits, advice is sought from insurance agents and brokers. Studies are made of available benefits *versus* price charged. The carrier that is selected is the one that appears to offer the most in benefits for the least money. Not infrequently, agreements are made with a particular carrier to serve as the union's recognized carrier of choice. But very shortly the union learns, as do employers, that this is not the way to plan a health benefit program and professional advice is sought and programs are planned to meet the needs of the particular employe group. More and more unions are employing full-time specialists in health and welfare benefit planning and are realizing that the problem is far more complicated, over the long term, than selecting carrier and benefit provisions in relation to an established quoted rate.

WANT STANDARD BENEFITS

In the future there will be increasing emphasis on full employer financing of the health protection program. Every union from which information was obtained has a noncontributory health program as its goal. Most unions, however, want to negotiate satisfactory benefit levels, as well as full-range health benefits, before establishing the principle of noncontributory financing. The trend is away from bargaining for money and then tailor-making the benefit package to the funds available. Bargaining is more and more for a specified standard of benefits. The employe's contribution, if any, is fixed with the employer financing the remainder of the cost, whatever the amount. The advantage of this approach for the union is that the employer agrees to provide stipulated benefits for a fixed and given employe contribution. It means during the life of the labor-management contract that rate increases are absorbed entirely by the employer. This approach, however, not only means that the employer will become increasingly concerned with factors affecting cost of benefits, but also means that the union tends to shift to the employer responsibility for providing the level and type of benefits set forth in the collective bargaining contract.

In the next five to 10 years the employer's over-all cost of health benefits, without any increase in present levels of protection, can be expected to increase from 5 to 7 per cent or more a year. If we make allowances for expansion of health benefit programs —more liberal benefits and broader eligibility provisions—and an increase in the proportion of the cost paid by the employer, it is reasonable to expect, on the basis of present trends, that the employer's expenditures for health benefits will increase from 200 to 300 per cent, or more, over the

next 10 years. Inevitably this will contribute to an accelerated employer interest with all of the factors that push the costs of health benefits upward, including organization of services and efficiency of administration at all levels of operation.

A significant observation in the analysis of labor opinion is the belief that the nonprofit community prepayment plans were the type of prepayment agency most likely, over the long term, to meet employe needs. In no instance, among the persons whose opinion was given, was there support for the insurance company cash indemnity approach. Some unions, of course, felt the only way labor needs could be met was through labor administered or labor-management administered agencies, but this point of view did not predominate except as a last resort alternative.

FAVOR NONPROFIT PLAN

The reason for favoring the nonprofit community prepayment agency varied, of course, from union to union. In general, however, the labor officials thought that the nonprofit plans were not only the best opportunity for a comprehensive "service benefit" approach but that they also offered an opportunity for consumer participation in policy making. The desire for participation in policy making is fundamental and can be expected to continue. The statements made on this issue were articulate and showed that considerable thought is being given to this point. Also, it was expressed in various ways that the nonprofit plans, in contrast with the insurance company approach, could act as an effective liaison agent between the purchaser of protection and the providers of services.

Every union official from whom information was obtained for purposes of this paper, without exception, expressed as a primary objective labor's desire for "comprehensive" protection. Although the concept of "comprehensiveness" varied somewhat from union to union the meaning of the term was essentially the same in all instances. So consistent, and persistent, were the demands for "comprehensive benefits" that the trend in this direction can certainly be expected to continue. Unions with cash indemnity benefits, and the few with deductible and co-insurance provisions, stated specifically that their union's goals were full "service" benefits. The pressures for "comprehensive service benefits" are undoubtedly too strong to be permanently offset, even at the price of a major strike, by various devices which would shift a significant portion of the risk to the provider of services or to the patient at the time of illness.

Without qualifications, the specific health benefit problem of greatest concern to labor officials is the matter of "service" benefits for physicians' services. The president of one large A.F.L. international union summarized the opinion obtained from labor officials with more restraint than most, when he said in the September-October 1955 issue of his union's monthly publication:

"The application of indemnity features in accident and health insurance has always baffled me. I know of no other field of insurance in which so many price tags appear. For example, I have collision insurance on my car. Of course, it has a $50 deductible clause, a principle, by the way, which I consider wholly inapplicable to health insurance. But nowhere in the policy do I find anything which says the company will pay so much for a crumpled fender, so much for a sprung door, or so much for a broken windshield. If the car is in a collision I take it to a repair shop, after proper arrangements have been made, and have the damage repaired at the expense of the insurance company.

"But when it comes to the human body the insurance companies go around hanging price tags on the allowable price for services to remove ailing tonsils or appendixes or to set broken limbs.

"Beyond this, there are grounds for believing that the application of the indemnity to surgical and medical insurance has played a part in increasing the cost of medical care. Many unions negotiated health plans underwritten on the indemnity basis. That may seem at odds with what I am saying about labor's wants in health insurance, but when unions started negotiating health and welfare plans they had to take what was available. In case after case where the union negotiates higher schedule benefits in an attempt to relieve the covered employes of additional medical costs, the level of medical charges rises soon after, leaving the covered employes no better off than they were before. Now, this phenomenon may be logical in the light of the sliding-fee system of medical charge based on ability to pay, since, in a way, the insurance benefits constitute an additional resource to the patient. But the ultimate result will be to convert health insurance to a benefit plan for the physicians."

ADDITIONAL CHARGES

Some time ago, speaking at a state medical society meeting, a C.I.O. official responsible for health benefit planning stated:

"A recent study which we made in one of the largest steel companies in western Pennsylvania shows that nearly 50 per cent of the bills rendered by physicians under our Blue Shield program required an additional payment by our members over and beyond the reimbursement provided through the Blue Shield schedule. Of these additional payments, one-fourth involved extra payments of over 50 per cent of the amounts allowed by the Blue Shield. While I do not have any figures to make comparisons between the situation now and when we first started in 1950, I believe I can state with confidence that the situation is becoming progressively worse from the volume of complaints we receive on this score.

"What do I mean when I say we must have service benefits under our surgical and medical care program and why do I feel justified in making this proposal to you? By service benefits I simply mean this: We propose a program which will pay the physician's bill in full for medical services rendered to steelworkers under our insurance program. This means that there will not be any additional charges to the insured person, but it does not necessarily mean that every similar procedure will be paid for at the identical rate."

Another labor official, an A.F.L. man responsible for the thinking of a major segment of organized labor, had this to say:

"Few experiences have been more frustrating to our members than that which many union groups have encountered in the fruitless effort to catch up with the will-of-the-wisp of rising medical and surgical charges by negotiating expensive increases in the benefit schedules of cash indemnity plans.

"Increases in benefit schedules negotiated in the effort to approach full prepayment of costs have served only

(*Continued on Page* 144)

Another Vote for Doctors on the Board

There can be no true partnership between hospitals and doctors unless doctors are allowed to participate in the management of hospitals

ROBERT S. MYERS, M.D.

THERE is increasing concern among members of the American medical profession that the control of medical practice is being concentrated in the hands of lay people who constitute hospital governing boards. This concern has led to a swelling demand from the medical profession that physicians be privileged to serve on hospital governing boards, and there is abundant and well publicized evidence during the last four years from such widely separated places as California, Connecticut, Florida, Indiana, Iowa and Washington that the profession intends to press its claims. There is also evidence that hospitals will resist these claims. Since a showdown between physicians and hospitals might affect adversely the care of patients, whose welfare is the only reason for the existence of hospitals, it is essential that the conflict be resolved with justice and dispatch. An understanding of the background of the conflict may facilitate an early and equitable solution.

ORGANIZATION IS JERRY-BUILT

The hospital-physician conflict is the inevitable result of the illogical, jerry-built organization which characterizes most hospitals. To begin with, there exists an incongruity by which the legal and moral responsibility for the welfare and safety of the patient is vested in a lay governing board which is not qualified to judge the quality of patient care given by the medical staff. Moreover, this lay governing board is placed in the untenable position of exercising the ultimate authority over the policies and activities of a medical staff which by training and experience is expert in the sole reason for the hospital's existence—the care of the sick. Furthermore, these lay people are handicapped by the present lack of reliable and intelligible hospital statistics which could indicate the adequacy of patient care. Hospitals are indeed unique. No other organization exists in which management may be so truly frustrated and so ineffective because of its incapacity to judge the quality of its product.

The conflict is further intensified and complicated by a second idiosyncrasy of organization peculiar to hospitals. This is the emergence of an authority competitive with that of management and results from the inevitable dominance which accrues to the medical staff: Hospitals exist only for the care of the sick; this care can be given only by physicians; the patient-physician relationship is strong and abiding; the services of the physician are in constant and apparent demand; the services of the governing boards are not. Thus, there arises a level of physician power which is frequently not compatible with that of the governing board, since the very tangible authority of the medical staff is subservient to the intangible authority of the governing board.

In the third place, as a result of the competitive authorities of the medical staff and governing board, there exists frequently no direct line of authority by which policy adopted by the governing board can be enforced by its agent, the administrator. In such cases the authority of the administrator is either ignored or is not respected by either the governing board or the medical staff, and the required point of single contact between the governing board and the medical staff, so essential for adequate administration, is absent. It is little wonder that such an administrator is frustrated and that the hospital acquires a split body and a split personality.

HOW TO SOLVE CONFLICT

What then should be done to resolve the hospital-physician conflict? The answer seems apparent: Create an effective and logical hospital organization in which authority proceeds from a competent governing board directly to the administrator and through him to the heads of the various departments of the hospital (medical staff, paramedical personnel, business office). This authority must be definite, direct and respected by all parties. Of prime importance is the establishment of a governing board which is qualified to discharge all its responsibilities, the most important of which is the maintenance of adequate patient care. Since this requires the governing board to understand the effectiveness of the professional work of the medical staff, it is logical and reasonable to place physicians from the active staff on the governing

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Presented to the Michigan Hospital Association, Grand Rapids, November 1955.

Dr. Myers is assistant director of the American College of Surgeons.

THESE ARE THE REASONS

1. Physicians contribute to the effectiveness of policy making.
2. Only physicians can explain medical matters to a lay board of trustees.
3. Physicians are an integral part of the team and they should be represented.
4. They should take their share of responsibility for nonmedical problems.
5. Physician membership on the board will solve the problem of competing authority.

board. This suggestion is contrary to usual hospital policy, and it is thus necessary to evaluate the stated objections to such physician participation. Over the years the following reasons (italics) have been offered, and are still used, to exclude physicians from hospital governing boards:

1. Membership on the governing board gives individual physicians undue publicity and possible professional and financial advantages over their colleagues.

This statement attaches unwarranted prestige to board membership which is usually a labor of love and does not of itself increase the prestige and business of lawyers, bankers, labor leaders, housewives and other citizens who serve so ably and devotedly in this capacity. Furthermore, it reveals a naïve misunderstanding of the ethics of the medical profession in regard to personal publicity. Nothing lays a doctor open to criticism and censure by his colleagues as quickly as unwarranted publicity. It is a principal seldom violated with impunity. The statement has also been made that a physician board member might receive special consideration by the hospital admitting office in the admission of his patients to the hospital. There is no valid reason this should be so, and this objection would be eliminated by the policy of rotation of physicians on the board.

2. Physicians who are members of the governing board may use this position to obtain unwarranted promotion on the medical staff.

If the by-laws of the hospital specify that a physician must be a member of the active staff to be eligible for membership on the governing board (and this provision is entirely reasonable) then the only promotions possible would be to higher rank in a service of the medical staff or to a category of unrestricted privileges in a particular specialty. Both of these promotions are determined by various responsible committees of the medical staff on the basis of professional competence and not because of pressure tactics.

3. Physicians appointed to the governing board are not regarded as representatives of the medical staff.

4. Physician representation on the governing board creates jealousy and frustration among other physicians who have no such connection.

5. The physician member of the governing board may be regarded as a "stool pigeon" who informs on the medical staff.

6. The specialty or particular field of interest of the physician board member might influence his recommendations of equipment and personnel to the disadvantage of other services of the medical staff.

Each of these objections may be disposed of by a requirement in the hospital by-laws specifying that the term of an individual physician on the governing board is limited to no more than two consecutive years at one time and that physician board members are to be elected by the members of the active medical staff. Rotation of the privilege of serving on the governing board would thus be assured, and any member of the active medical staff would be eligible for the position.

7. The physician on the governing board may be exposed to double jeopardy in certain legal actions.

It is not known how infrequently such an eventuality might occur, but it would seem that the physician board member is relatively secure from this hazard. However, this is an objection which should properly be considered by the physician, since he provides for his own personal professional liability insurance.

8. The physician on the governing board might express his own opinion and not that of the medical staff.

The physician, like any other member, is on the board in the interest of the patient and not to represent any special group.

9. The physician on the governing board may use his influence in the employment of hospital personnel.

This assumes wrongly that physicians are less honorable than other members of the board. It also fails to recognize that the now existing dual authority in hospitals permits physicians to by-pass the administrator and to exert considerable influence on the employment of hospital personnel.

10. Leading authorities in the hospital and medical fields advise against physicians being on governing boards.

COMMISSION CHANGED RULE

It is true that the American College of Surgeons, during the time it conducted the program of hospital standardization, discouraged physician representation on governing boards and deducted a few points from the rating of any hospital which had physicians on the board. However, the Joint Commission on Accreditation of Hospitals, which succeeded the college in this program, does not share this view and does not penalize hospitals having physicians on the board. Moreover, the 1953 report of the Joint Committee on Hospital-Physician Relationships of the Boards of Trustees of the A.M.A. and the A.H.A. recommended that "members of the medical staff can be members of the hospital governing board" as one method by which the medical staff may have access to the board.

11. Since it is unethical for lay members of a governing board to profit from business transactions with the hospital, it is equally unethical for a physician to serve on the board of a

hospital to which he admits patients.

This objection fails to recognize that profit for a lay member of the board would be the direct result of a decision by a board on which he sits, whereas profit for a physician must come from professional practice, the increase of which is not influenced by a decision of this board.

12. Admission of physicians to membership on hospital governing boards is the first step in the eventual total domination of hospitals by the medical profession.

The value of community participation in the management of the hospital is well established and is well recognized by the medical profession. The profession has no desire to assume the total responsibility for the management of the hospital.

Having thus revealed each of these objections to be nonvalid, it is timely to indicate the distinct advantages of having physicians on governing boards of hospitals:

1. Physicians can contribute much to the effectiveness of any policy making body, for they are trained in deductive reasoning and are accustomed to making important decisions. They take their responsibilities seriously and discharge them with distinction. Moreover, physicians have firsthand knowledge of the deficiencies and needs of hospitals, both from their own observations and from their patients' comments.

2. Physicians alone can explain medical matters to lay members of the governing board, and they can do this best when they participate as responsible members of the governing board. Joint conference committees, composed of representatives of the governing board and the medical staff, afford only limited communication between the board and the staff and rarely acquaint the entire board with an adequate understanding of factors affecting patient care. It is logical that a physician should participate as a member of the board when decisions on medical matters are made by the board.

3. Physicians are an integral part of the hospital team and of the community. It is reasonable and democratic that they should be given representation on the board. Moreover, since it is recognized that representatives from all other elements of the community (business, law, clergy, labor, housewives) bring to the governing board the benefits of their natural talents, special training and experience, it is entirely logical that the physician's special knowledge of medicine would be of value to the board.

4. Physicians, as part of the hospital team, should take their share of responsibility for the nonmedical problems which face administration of hospitals. The reasonable reduction of expenditures and the raising of money should be the concern of the medical staff and will be if physicians are integrated properly into the policy making body of the hospital.

5. Physician membership on the governing board will ensure the ultimate authority of the governing board and will abrogate the competing authority otherwise assumed by the medical staff. Once the governing board is reconstituted to include physician members, it is necessary that a distinct line of authority be laid down from the board to the administrator and through him alone to the head of each department of the hospital. Any attempt to by-pass the administrator from above or from below violates a cardinal principle of effective organization and must not be tolerated. Policy established by a governing board which includes physicians is binding on all components of the hospital, including the medical staff. There is no reason to anticipate failure of the medical profession to cooperate. In fact, it is the experience of hospitals which have welcomed physicians to membership on their governing boards that physician-participation has created an effective and harmonious hospital organization not previously present.

Of necessity, hospitals and the medical profession are joined in permanent wedlock, for one cannot now exist without the other. This marriage must succeed, not only to protect the patient but also to perpetuate the American ideal of free enterprise for hospitals and the medical profession. But if this union is to prosper, there must be a true partnership between hospitals and physicians. This will not be realized until physicians participate in the management of hospitals and share in the responsibilities attending this privilege.

Michigan Hospital Association States New Policy of Helping Members in Litigation

GRAND RAPIDS, MICH.—The Michigan Hospital Association will assist member hospitals involved in litigation provided the main issue of the litigation is of definite concern to a substantial portion of the association membership, it was decided at the 36th annual convention of the Michigan Hospital Association here last month. Following discussion of association participation in doctor-hospital litigation in the case of the Grandview Hospital at Ironwood, Mich., in 1954, and the Allegan (Mich.) Health Center in 1955, the association's house of delegates adopted the following policy concerning association participation in litigation affecting member hospitals:

"Subject to further modification by the board of trustees, it shall be the policy of the Michigan Hospital Association when requested by a member hospital to assist it in litigation, to render assistance on the following basis:

"1. The main issue of the litigation must be one which, in the judgment of the trustees, is of definite concern to a substantial portion of the association membership.

"2. In such cases, the services of the association legal counsel will be available to the member hospitals for consultation.

"3. Financial assistance will be provided only on appeal to the supreme court and will be limited to the available resources of the association, as determined by the board of trustees.

"4. Decision as to whether or not assistance shall be given will be made by the association trustees after careful consideration of the individual case."

The Grandview and Allegan cases necessitated careful reexamination of association policy concerning participation in litigation, Andrew Pattullo of the Kellogg Foundation, Battle Creek, said in his report as president of the association.

Mr. Pattullo also recommended that the association should consider including osteopathic hospitals as members.

"I have felt for some time that our association should not be an exclusive society," he said. "I do not believe that by accepting osteopathic or osteopathic-M.D. hospitals we will lower

(*Continued on Page* 166)

Special Report

HOSPITALS AND THE GENERAL PRACTITIONER

The report in the following pages was written by Dr. John S. DeTar of Milan, Mich., president-elect of the American Academy of General Practice. Commenting on the report and how it came to be written, Dr. DeTar told *The Modern Hospital:*

"The American Medical Association Committee on Medical Practice (Truman Committee) included this recommendation in its report: 'That the American Medical Association continue to use its full influence to discourage arbitrary restrictions by hospitals against general practitioners as a group regardless of their qualifications as individuals.'

"I wished to ascertain whether arbitrary restrictions actually existed and, if so, what type of restrictions. I therefore asked Dr. Charles C. Cooper of St. Paul, chairman of the Academy's commission on hospitals, to attempt to get this information from those who would be in the best position to know—the officers of the various state chapters of the Academy.

"This report is based on the replies received. It is not a quantitative national survey. It does not indicate nationwide conditions. It does, however, point out the type of problems faced by the generalist in his hospital relations. No effort was made to prove or disprove the statements contained herein. The report therefore is a compilation of physicians' attitudes based on their own appraisal of their own hospital problems.

"In retrospect it appears the medical profession is in complete agreement on the proposition that these problems do exist and that action must be taken to eliminate exclusion and undue limitations of the generalist in his hospital affiliations and privileges. The unanimous action of the American Medical Association House of Delegates on Dec. 1, 1955 (see page 49), in approving these recommendations is an indication of the seriousness with which the medical profession views these problems."

As the details presented here plainly indicate, some arbitrary hospital restrictions on general practitioners do exist. However, the careful reader will note several facts about this report before reaching any broad conclusions about restrictions on general practice by hospitals.

1. Dr. DeTar's inquiry was addressed to chapter officers of the Academy and frankly asked for examples of restrictive practice—a method calculated to bring out the most unfavorable facts.

2. Even so, a third of the respondents had no complaints at all, and the total number of hospitals covered in the survey was so small as to have little significance statistically.

3. For the most part, the reports presented here came to Dr. DeTar from the injured or affected parties themselves, or from their associates in general practice in these communities —scarcely to be considered unprejudiced sources of information on this subject.

4. As Dr. DeTar himself points out, the reports are unverified, and, in several cases, the facts reported here have already been challenged by others familiar with these hospital situations.

Notwithstanding all these qualifications, the report unquestionably shows that some hospitals have gone beyond reasonable bounds in restricting or excluding the general practitioner. The reasonable bounds have been established by the Joint Commission on Accreditation of Hospitals: "The Joint Commission has approved the formation and function of a department of general practice in the hospital staff organization," a past president of the American Academy of General Practice said recently. "Therecommendations include the stipulation that members of the general practice department shall have the privileges of the clinical services according to their demonstrated ability, skill and judgment. No more clear-cut statement could be made."

With the good intention of safeguarding and improving care of hospital patients, the hospital that excludes the general practitioner may actually be doing a disservice to its community: The physician who is cut off from hospital contacts may be expected to suffer professionally, and his patients may be expected to suffer.

—The Editors

Special Report

HOSPITALS AND THE GENERAL PRACTITIONER

JOHN S. DeTAR, M.D.
Milan, Mich.

DESPITE the doubling of the number of general practice departments in hospitals within the last three years, the plight of the generalist in his hospital relationships has worsened and deteriorated in many sections of the country. Despite the tremendous growth of the American Academy of General Practice to 20,000 members in eight years, the problems of the general practitioner loom today as the greatest single intramural challenge facing the American Medical Association.

It has been my opinion that the health of the American people is properly the business of the American Medical Association; that if the generalist is being limited in his hospital privileges to the point where his efficiency as a family physician is being negated, the health of the American people will suffer; that the American Medical Association, with about 60 per cent of its membership engaging in the general practice of medicine, must take more than a passing interest in the problems currently facing the generalist, and, finally, that if evidence indicates that present trends are leading toward a reduction in the supply of generalists, it becomes the duty of the American Medical Association to adopt firm stands to correct those trends, be they in the fields of formal medical education, internship and residency, or that of hospital relationships.

Some educators and specialists are convinced that the generalist should be limited to a small orbit including office and home calls only; that he should be stopped on the front step of the hospital, entrusting his patients to complete specialist care within the hospital. Others, among them the majority of educators and specialists, recognize in such a system the threat of the elimination of the family physician, with an increasing spiral of medical costs culminating in government control of medical practice.

The American Medical Association has taken cognizance of the situation. At the present time, in addition to warnings repeatedly voiced by the Council on Medical Education and Hospitals, three A.M.A. committees are studying various aspects of the total problem. These are:

1. The Committee on Medical Practices, whose principal recommendations were approved by delegates at their December meeting at Boston. One recommendation of this committee was: "That the A.M.A. continue to use its full influence to discourage arbitrary restrictions by hospitals against general practitioners as a group, regardless of their qualifications as individuals."

2. The Committee on General Practice Experience Prior to Specialization, which has gathered some significant statistics, and has been instructed by the house of delegates to continue its studies.

3. A special committee to consider a resolution on general practice introduced in the December 1954 meeting of the house of delegates. This resolution called upon the A.M.A. to conduct an exhaustive investigation of the problems of general practice including medical education for general practice and the effect on the quality of medical care created by the limitation of hospital privileges of general physicians. This committee is now at work.

In order to acquire up-to-the-minute information on the extent of the problems involved in hospital practices among generalists, the chairman of the Commission on Hospitals of the American Academy of General Practice, Dr. Charles C. Cooper of St. Paul asked the men throughout the country who should be the closest to these problems, officers of the state chapters of the American Academy of General Practice, for specific examples of arbitrary restriction of privileges. One hundred and seventy replies poured in from 40 states.

This article represents an effort to analyze those 170 pieces of evidence. Many direct quotations are utilized. To me, the conclusion is inescapable: The need for definitive action by the American Medical Association is pressing.

Survey Requested Specific Examples

In this survey, specific examples were requested, with names and dates and hospitals involved, together with a detailed description of the restriction. The replies are presented for your consideration. Names are omitted to save the writers from possible embarrassment. The answers are grouped into six classifications:

1. No complaints of restrictions.
2. General hospital restrictions.
3. Restrictions in the department of obstetrics.
4. Restrictions in the department of surgery.
5. Assorted restrictions, such as in anesthesia, pediatrics and bed allocations.
6. Complete exclusion from hospital staff membership.

The replies, with some interpretive analysis, follow.

It goes without saying that some readers will see in this evidence only

This report is also being presented in the January issue of GP.

the anguished cries of a class of physician destined by the advance of specialism to eventual extinction in the interests of higher and higher standards of medical care. Others will recognize with dismay the throttling tactics of one class of physician aligned against another in a struggle for life. Still others will weigh the evidence in the light of the expressed desires of the American people for personal, family physicians in the generalist classification, and will decide that it is high time for the American Medical Association to express policy in unmistakable terms.

One-Third of Replies: No Restrictions

About one-third of the replies stated that there were no arbitrary restrictions on the generalist in the hospitals of their areas.

These came from smaller communities throughout the country, and from some areas including cities. States included in this list are: Washington, Nebraska, Michigan, Mississippi, Wisconsin, Texas, California, Connecticut, Iowa, Indiana, Oklahoma, Maine, Kentucky, Idaho, North Carolina, Nevada, Missouri, Colorado, Vermont, Louisiana, West Virginia, and Utah.

Entire states are not indicated by this list; only localities. From some states came conflicting reports, dependent on local conditions.

Here are examples of some of the replies in this group:

Washington: "I have no personal knowledge of any unfair treatment in eastern Washington, northern Idaho, or western Montana. Medicine is being practiced here as it should be."

Texas: "This city has been the site of some arbitrary general practice restrictions in the past. We are working now toward the complete alleviation of these arbitrary restrictions and things seem to be going along at a very good clip at this time."

Virginia: "Any general practitioner who opens an office in this city is entitled to general privileges within 30 days after making application."

Oklahoma: "I had a four-year fellowship and in 25 years have done 2900 goiters. There is no restriction on general practitioners here. But, I would not be allowed to do a thyroid in some hospitals in this state."

Nevada: "There is no difficulty here. General practitioners are permitted to perform any surgery—other types of cases also—that are within their capabilities. There have been a few disgruntled doctors from time to time, but that is quite natural. They were flagrantly violating their reasonable limits. I know of no instances in the state where general practitioners are not properly taken care of in the category of privileges."

Colorado: "In most hospitals restriction of staff or department privileges is on an individual basis, and while some complain bitterly it is usually those who should be restricted."

A statewide survey of general practice in one state disclosed these answers:

Is your staff controlled by surgeons? Yes, 6; no, 57. By a group of specialists? Yes, 11; no, 50.

Is there a restriction of general practitioner's activities in this hospital even though he is qualified? Yes, 5; no, 69.

Is there provision to allow general practitioners to obtain privileges by demonstrating their ability? Yes, 62; no, 2.

Are recent graduate general practitioners allowed privileges similar to those of older men? Yes, 46; no, 22.

Are you restricted on admission of patients? Yes, 0; no, 65.

This survey indicates that the generalist fares rather well in this state.

More than 50 of the replies could be classed in the category of "no complaints." Many qualified their remarks. For example, a doctor from Omaha, Neb., said, "I know of no restrictions of general practitioners to do anything they are qualified to do." This, of course, is an ideal situation.

Some said more restriction of unqualified physicians was, in fact, needed. Many replied that the work of the American Academy of General Practice had reestablished the generalist to his rightful place on the hospital staff.

A correspondent from a West Coast city replied that there are no restrictions of privileges, but that "there are some pretty irritating hospital rules which have been pushed by surgeons in our hospital."

Many replied that constant work of the departments of general practice had thus far aborted successfully the attempts at undue restriction.

Several, such as a writer from Maine, replied that their problems had been satisfactorily handled by the existence of a department of general practice within the active staff of each hospital.

A long-time practitioner in Minnesota says that there are no undue restrictions in Minneapolis, although "we have so-called specialist hospitals, and so-called general practice hospitals."

An able young practitioner in Washington says that "the only restrictions here are for demonstrated incompetence."

Many replies indicated that although privileges have not been curtailed to date, there were indications that this might be the tendency. A man in Nevada says, "The general practitioner is in a somewhat precarious position in our hospitals, although both hospitals have extended privileges to general men who are qualified." Another in Utah says, "There is no specific case, but there is a general feeling about the hospital which favors the specialist at the expense of the general practitioner. This is especially true of the so-called 'board-eligible' specialist in general surgery."

A prominent practitioner in Iowa tells how their problem was handled. Says he: "I feel that our situation is healthy because we have been aggressive. Two years ago, when the American College of Surgeons was making such a ruckus, we called some meetings of the general practitioners of the city. About all we did was to have dinner and talk things over, but we sent articles to the papers about our meetings, and we really put some of the specialists in line in a hurry. There is no question in my mind but what the American Academy of General Practice has been of great benefit to men who are doing general work here."

An Academy member in Oakland, Calif., has this to add: "The majority of cases of supposed restriction I have observed have been cases of restrictions applied because of incompetence and inability of the general practitioner to evaluate his own limitations."

One-Fourth Report "Undue" Restrictions

Statements that generalists were restricted arbitrarily and unduly came from 44 areas. This amounted to approximately 26 per cent of the total number of areas covered.

Distribution was wide, these replies coming from Connecticut, Minnesota, Ohio, Kentucky, Oklahoma, Illinois, New York, North Carolina, Tennessee, Massachusetts, Arizona, New Jersey, Georgia, Missouri, Michigan, Indiana, Colorado and West Virginia.

Details vary greatly, but the pattern is similar: the gradual restriction of the hospital privileges of the generalist. It is impossible to appraise accurately the virtue of these complaints. Certain it is that some generalists will object to any restriction. However, some of the situations described indicate restriction of the generalist which is not in the interest of the patient and not contributory to a high level of medical practice in hospitals. If the generalist is restricted to the point where interns and residents feel forced to enter specialties in order to practice medicine in hospitals, it follows logically that the dearth of generalists is destined to increase. Whether this is in the public interest is one of the most important matters facing the American Medical Association.

Some of the comments on the general restriction of the generalist are interesting:

From New Jersey: "In general, I can say that in 10 more or less general hospitals in this city there has been a gradual but definite attempt to restrict the general practitioner more and more. In the obstetrical department a general practitioner cannot even break membranes or do a simple episiotomy without permission of the obstetrical resident—mind you, not even the attending obstetrician."

One doctor from Virginia who has given much thought to the question believes something must be done to relieve the pressure on the general practitioner. He writes, "We feel that liberalization of hospital privileges for qualified general practitioners is one of the most pressing needs on a national as well as a local level. For everywhere the general practitioner is having trouble. The hospital situation is bad for the general practitioner. Daily he has to turn his emergencies over to some staff man, always a specialist, in order to get a bed. In all fairness, the writer of this letter, being an old-timer, has little personal axe to grind. He is trying to secure for the young man an equality of privilege."

Another area reported that there were 21 doctors doing general practice, but most of them were reluctant to be identified as general practitioners. "This stems from the fact that they will have no staff privileges if they are known as general practitioners," the report said.

Three New York Hospitals Say No

The Medical Society of New York County recently conducted a survey among voluntary hospitals regarding departments of general practice. This survey asked if the hospital had a department of general practice, if general practitioners functioned in its dispensary, if general practitioners were allowed to assist surgeons, if the hospital desired a department of general practice, and if the hospital was willing to accept properly qualified general practitioners to work through the various clinics. To every one of these questions, the answer was an unqualified No, from three well known voluntary hospitals. When these hospitals were asked if they objected to having general practitioners on their staffs, they answered with an unqualified Yes.

A practitioner in Virginia tells this story: "In 1947 I was granted privileges in general practice. I did a great deal of major surgery and major obstetrics. During the first years of my practice this was always done with assistance and later in almost every instance with consultation, although in many instances I did not then require assistance during the procedure. Since my return there have been many young specialists settling in this area. As they have come in, the desire to restrict the general practitioner has been increasingly evident. At the present time there have been several revisions of the constitution and by-laws of our local nonprofit hospital with further restrictions of general practice in each instance. There has at no time been a hearing or a discussion of cases or a specific charge of a violation of rule; and yet privilege which I was granted and which I practiced until 1950 has now been restricted so far that it is virtually impossible for me to conscientiously enter a gynecological case without assuming the rôle of assistant to some board qualified diplomate, although the procedure may be one which I have done a great many more times than did the person on the right side of the table. It has been impossible to bring this matter before the staff as a whole, although the general practice section of the staff discussed it and supported me in the work which I had been doing previously. The recommendation, however, was completely ignored by the credentials committee and the executive committee."

This correspondent then describes the plight of the young, well trained generalist entering practice. He continues: "My associate trained last year as an assistant surgical resident. He decided to enter general practice and associate himself with me. He applied for privileges in general practice in the hospital in which he received his surgical training. He requested that he be allowed privileges in general practice to include the treatment of children, medical cases, simple fractures, so-called normal obstetrics, and minor surgery. In answer to this request came this letter: 'Our interpretation of general medicine does not include such specialties as pediatrics, obstetrics, or any of their subspecialties.'"

A medical school teacher of Tennessee decries the restrictions at a hospital there. He states: "A physician with less than board qualifications is not given an opportunity to demonstrate his ability or to improve his staff rank or privileges. These are granted entirely on the basis of length of time in a residency, and no consideration is given to any other type of training or experience or to individual ability or aptitude.

"At the present time, only the young doctors suffer greatly from this discrimination. However, if present policies continue in the future, no general practitioner will be able to care for his patients' surgical conditions (major and minor) and many will be forbidden to use the hospital entirely. This means that these doctors are not able to give the best possible medical care to their patients—not because of lack of ability, but because they are arbitrarily restricted more narrowly than their actual limitations justify."

The current tendency to restrict the generalist to a single department in a hospital is described by another correspondent. He says, "After practicing in one hospital, but not frequently, for 22 years, and having no restrictions, request was made that I file a formal application for staff membership, and I was told that now I could have major privileges in any department—surgery, medicine or obstetrics, but in only one. From now on, if I chose to do obstetrics, I would not be allowed to do major surgery or medicine, all of which I have done there, and still do in every hospital in the city. I withdrew my application."

The generalist allegedly has difficulty in caring for his emergency cases at a Connecticut hospital. A staff member there reports that he no longer has privileges in the emergency room but must call a board qualified surgeon when his cases are admitted to this hospital. He has transferred cases he believes within his field to another hospital where he holds surgical staff appointment.

Describe "Anti-Generalist" Feeling

A great many generalists throughout the country describe an attitude which they believe is growing, although they have no complaints about their own privileges. A Minnesota doctor refers to the "pro-specialist" and "anti-generalist" attitude he has observed, and believes that much of the problem facing the generalist can be classified as "insidious opposition" within the hospital staff.

Local medical politics appears to be a factor in granting proper privileges in some hospitals. From Kentucky comes the report that for four years the generalists on the staff of a hospital attempted in vain to regain their rights to minor surgical privileges. Not until the retiring president of the hospital staff needed the assistance of the generalists in support of his nomination for presidency of the county medical society was any progress made in this direction. Says this writer: "Then, he was able to open this hospital for those privileges in 30 minutes." He adds: "This case is representative of the asininity involved in the entire problem of restricting the activities of generalists."

Peculiar limitations are not exceptional. Another Kentucky practitioner reports that for many years he had given anesthetics for surgery performed by otolaryngologists. When he was requested to administer anesthesia for an ophthalmological procedure, he was informed that his anesthesia privileges were restricted to otolaryngological procedures, and did not include ophthalmology.

The ethics of a secret credentials committee come in for scant praise

from this correspondent. He claims he has waited for 10 years for an answer to his application for general practice privileges at the hospital where he had full privileges prior to World War II. On returning from service, he reapplied. This was in 1945. He received no answer. He reapplied in 1948. He is still awaiting an answer. This delay he ascribes to a secret credentials committee appointed by the hospital administrator. He says, "All attempts to find out the reasons for this action have run into a brick wall."

Repeated Applications—No Answer

From Oklahoma comes a similar story: "I have made repeated applications for staff membership and privileges at St. John's Hospital. I have never received a written answer. I have been placed on the courtesy staff with no privileges. I cannot admit a patient for any purpose. I have had patients go to this hospital and ask that I be called to attend them only to have the request refused and a specialist employed by necessity. There are many practitioners who share my experience but through fear of ostracism hesitate to commit themselves in black and white." He then lists six generalists who have shared this discrimination because of being general practitioners. He offers convincing evidence of discrimination against a class rather than an individual.

The formation of a department of general practice is described by an Arizona doctor as no answer to the problem of proper privileges for generalists. He writes: "My hospital has attempted to set up the hospital for specialists only. The battle has been in progress for the last two years, becoming progressively worse. Unfortunately, they have ample grounds to deny this since they have set up a division of general practice which is virtually nonfunctional. It has been impossible to get anyone to sign an affidavit to this effect because of the criticism he would undoubtedly get."

One recipient of the questionnaire in Virginia agrees wholeheartedly with the foregoing comments. Says he: "No generalist has the opportunity to do general medicine in this hospital except some few who have been on the staff 15 years or longer. The general practice department is really a department on paper only. Generalists serve as admitting M.D.'s to channel patients to the 'proper' specialist clinic. No general practitioner can do pediatrics or obstetrics of any kind regardless of ability."

One correspondent in Maryland gives a spicy account of conditions there. He says, "A general practitioner may admit patients to a hospital over or under the age of 12, but not both. I refer to large hospitals. Simple lacerations cannot be sutured or abscesses opened in the emergency room. Obstetrics cannot be practiced by any recent (10 year) graduates unless they have had three years of obstetrical training. The rule of those in control is gradually being broken, and eventually they will be sent to the showers. However, first the Hospital Accreditation Commission must drop dead." I do not know how common this attitude is. However, the restriction of the generalist is apparent.

Recourse to the law was used by one general practitioner in Nevada. He writes: "Before entering the service in 1941, I had full privileges in a county institution. On discharge from the service, I was refused all privileges. The reason given by the administrator and by the executive board, consisting of a group of specialists, was that I was a general practitioner, and that they had decided I did not have the qualifications to practice in 'their' hospital. I revealed the situation to the district attorney. He gave them a reading of the law, and I was reinstated immediately."

Hospital Privilege Not a Right

According to the opinion of competent lawyers I have consulted, it is doubtful that the courts would sustain a doctor's demand for privileges as a right. However, it is a sad commentary on the practice of medicine in hospitals when this action must even be considered to gain his proper privileges for the generalist.

A note of encouragement comes from a Colorado respondent. He states: "No new generalists have been given staff privileges in our hospital for the last five years. However, the executive committee is exploring the possibility of accepting applications from general practitioners and is trying to determine whether the present limitations can and should be modified."

From North Carolina comes a statement of exclusion from voice in determination of policy within the hospital. A correspondent writes: "For the last eight years no general practitioner has been permitted to be a member of the active or associate staff of this hospital. Courtesy staff membership does not permit them to hold office or vote at staff meetings, and thus, they have no voice in the policy of the staff."

From Massachusetts comes a word of encouragement. The chairman of the hospital committee of the state chapter of the American Academy of General Practice reported the establishment of a depa.tment of general practice in several hospitals. He says, "This is a somewhat limited service at the present time but it is in one of our teaching hospitals and is certainly a step forward to a very desirable situation and will be watched with great interest. Several other hospitals have shown great interest in establishing a department of general practice, both for their staff and for residency training, so that we feel that we can report a definite trend toward the improvement of the training of general practitioners and hospital staff privileges in Massachusetts."

In surveying 1300 generalists in Massachusetts, this committee found that of 827 who replied, 126 (16.3 per cent) reported an improvement of their hospital staff privileges, and only 13 (1.7 per cent) reported that their status had become less favorable. Of those answering, 81.78 per cent reported adequate facilities and only 14.34 per cent reported inadequate facilities; 3.87 per cent reported no facilities.

This committee chairman concludes his report thus: "We feel that the Academy of General Practice has an extremely responsible rôle to play in the future of general practice, and to date has assumed this responsibility. With the constant striving for improvement among our membership, and continued cooperation with the medical schools, hospitals and other allied societies, the family physician will continue to be in his rightful place as the center of the modern and complex care of all patients."

In some areas there are few applications for general practice residencies. One correspondent explains: "After talking with many interns and residents, I am satisfied that the main determining factor in specialty training or general practice is hospital restriction or privileges based on formal training rather than on knowledge obtained in less orthodox fashion. Thus, the intern realizes once he has committed himself to general practice, certain doors will forever remain closed despite proficiency later acquired in individual procedures.

"Probably owing to such restrictions, most of which are not limited to one hospital, only 22 per cent of the new members of the county medical society in the past year have been general practitioners. Whether or not this is out of line with the demands of the population is a moot question."

Illinois survey results seem to support this conclusion. There, it is reported, "42 per cent of recent graduate generalists do not get the same break as far as privileges are concerned as do the older general practitioners. Twenty-one per cent reported that they have no opportunity to demonstrate their ability or to utilize their training and skill to the fullest."

Restrictions of OB Privileges

Many complaints about restrictions in the departments of obstetrics are being voiced across the country. These complaints vary from refusal to allow the physician to do an episiotomy to refusal to allow the use of forceps.

From Pittsburgh comes the report that in one hospital restrictions are as follows: "The nurse must phone to the chief of the department of obstetrics in order to get permission for the gen-

eralist to use outlet forceps. This must be done in each and every case. It is often done in the delivery room with the patient overhearing the procedure, much to the embarrassment of the family physician."

From Washington, D.C., comes a report concerning a physician who was on this staff as an O.B.-Gyn. instructor until the hospital changed ratings. He was then rated as a general practitioner, was given general medicine privileges (courtesy only), and from that time on he has not been privileged to admit an obstetrical patient.

Affiliation with a medical school is given as a reason for excluding generalists from the obstetrical department by a respondent in Ohio. He reports: "About 1946-47, many generalists were denied privileges in normal obstetrics. The explanation was that there was a shortage of beds, although I do not know of any obstetrician being denied beds, and that the hospital was affiliated with a medical school which insisted on specialists only performing deliveries."

From Florida comes a plea for the opportunity for all physicians to qualify as individuals rather than being denied privileges as a class. Writes one doctor: "On Jan. 26, 1955, the privilege of using outlet forceps was withdrawn unless consultation was received prior to application. This policy affects all general practitioners including several who have demonstrated their ability and judgment in the use of forceps over a period of many years. No member of the general practice section questions the advisability of consultation (free to the patient) in the use of mid-forceps, and none considers high forceps advisable under any circumstances. It is obvious, however, that this restriction was imposed on the general practice section as a group because there have been in the recent past one or possibly two incidents of improper use of outlet forceps by general practitioners. We believe this constitutes an example of unfair group restriction regardless of individual ability. The cooperation between the obstetrical staff and the general practitioners is excellent, but the necessity of a consultation for low or outlet forceps is both embarrassing and at times time consuming when the patient is under an anesthetic."

General Practice Departments

The manual on general practice departments in hospitals, published by the American Academy of General Practice and approved by the A.M.A., includes the following:

"To facilitate the training of practicing general practitioners in specialty fields in which they might wish to advance their education, it is recommended that the rules and regulations of the hospital provide for preceptorship training for them in the hospital. . . .

"The extent of this preceptorship training shall be determined by each individual specialty service of the hospital in collaboration with the credentials committee."

From New York State comes a report of extreme limitation. It reads: "A physician who had been a teaching obstetrician and surgeon in a medical college chose to do general practice because of a coronary. He was finally given privileges in the OB department other than normal deliveries (non-instrumental), but had extreme difficulty in securing such privileges."

Even more surprising is this note: "In this hospital baby circumcisions are done only by G.U. men, and not by the general practitioner or obstetrician." Such restrictions, on the simplest surgical procedure in the entire surgical field, cause wonderment.

Restrictions in Surgery

So much attention has been focused on the problem of granting surgical privileges to generalists in the face of constantly rising standards of hospital practice that it is surprising to discover that only 34 of the 170 replies dealt specifically with the problem. This constitutes only 20 per cent.

It is difficult to evaluate some of the complaints without detailed investigation and on-the-spot analysis of the qualifications of the physician who feels he has been the victim of unjust discrimination. A great many of our correspondents, however, evince concern about the younger practitioners and future practitioners, rather than about themselves.

An Academy member in Louisiana writes as follows: "All men who are not doing general surgery at the present time must have two years approved surgical residency to do major procedures. This ruling does not affect those members who are so doing now. No young general practitioner can qualify for preceptorship training for future surgical privileges. Fortunately, we have one or two other hospitals which do not limit privileges for those who are trying to qualify."

This man does not criticize the rising standards of surgical practice; but he does point out the elimination of incentive for the generalist to qualify through constant improvement and postgraduate study. This is the basic problem involved in the absence of takers for general practice residencies where only 56 per cent of the positions are filled. It is easy to understand why only 1.6 per cent of all filled residencies are in general practice when broadened hospital privileges are automatically cut off before the young general practitioner starts his practice.

Restriction of surgical privileges of the generalist for financial gain of surgeons is charged by one doctor of Nebraska. He states: "I have personally performed approximately 30 major cases under the guidance of an active member of the surgical staffs of two hospitals; I have performed about 25 D. and C.'s and about 50 tonsillectomies, and have assisted in more than 400 major surgical operations. Yet, I am not accorded surgical privileges. The local situation has come to the point where the member of the A.C.S. and the board qualified men have joined together against the general practitioner surgeons in an effort to control new surgeons getting on the active surgical staff without board qualifications or membership in the A.C.S. One of the board qualified men remarked to me, 'The general practitioner could handle 85 per cent to 90 per cent of the major surgery that he sees, but I (the surgeon) can't make a living on the other 10 per cent to 15 per cent.'"

Quite apart from major surgical privileges, many physicians are objecting to limitations which appear unnecessary. A general practitioner of Kentucky reports that he was refused permission to apply a cast to a small linear fracture of a metatarsal in an adult on a Sunday afternoon in the emergency room. He removed the patient to his own office and applied the cast. Another man in the same city has this to say about such restriction: "Such minute attention to small restrictions by petty officials hurts the respect between the general practice and the specialty groups, most of whom agree that this prejudice is senseless and uncalled for."

Certification as Index of Competence

Board certification rather than individual surgical capacity as an index for privileges comes in for direct criticism by a respondent from Wisconsin. Says he: "A former president of the county medical society, an able surgeon with professional reputation above reproach, suffered withdrawal of all his surgical privileges last year, not because of poor results, but because he is not board certified, or a member of the A.C.S. It is the policy of this hospital not to permit general practitioners to assist with the surgery of their referred patients."

Similar limitations are recounted by many others, including specific complaints from Ohio, Maine, Virginia and Georgia. These physicians object not to limitations necessary in the elevation of surgical standards, but to the exclusion of physicians who do general practice as a class, without opportunity to serve preceptorships in order to qualify as individuals.

In the face of these complaints from all over the country, it is interesting to

recount the statement issued by the Joint Commission on Accreditation of Hospitals in October 1954, when the commission asked the question, "Who may do surgery?" and answered its own question in these words:

No Specific Answer

"There is no specific answer to this question. Good surgery cannot be measured blindly by years of residency, preceptorship, or number of operations assisted at, or performed. Certain individuals, no matter how long or where their training, will never become good surgeons. Merit alone is the only criterion for judging physicians' surgical abilities."

If this statement of the commission represents the truth, then the practices of recognition of ability by certification of time spent in training, and of exclusion because of engaging in general practice, are not in conformity with standards set by the commission. This conclusion raises the very important point of approval of a hospital which does not meet commission standards. It is one which merits serious consideration by the American Medical Association and the commission.

In short, why should a hospital which fails to meet housekeeping regulations be disqualified when one which fails to meet professional qualifications (by judging physicians by their diplomas and their society memberships rather than their proved and observed ability) be approved? The A.M.A., which must and does formulate its policies in keeping with quality professional care of the American people, must also not evade this issue.

One of my correspondents from Oregon presents a very complete picture of the progresive generalist with surgical experience, continuous study, and constant effort at recognition rewarded by a complete brush-off by his surgical colleagues. I quote him rather voluminously because of the clarity of his statements. Says he:

"I practice in a city with one large hospital. As a generalist, it has been quite evident in the last 10 years that there has been a concerted effort toward limitation of the scope of practice of the general practitioner, which was not true before that time.

"Approximately five years ago, through our efforts, a training program was instituted along with the cooperation of the surgical department of the hospital, the essential features of which were that any general practitioner who wished to advance in surgical privileges could apply to the surgical department, and specific steps were made by which he could first do 50 assists, then proceed to present 50 cases of his own, on which the surgical department agreed to act as both consultant and assistant. Over a three-year period there was just one generalist who had advancement to what we call qualified privileges in our hospital.

"At the time that the training program was started, I personally applied for the program, though I had been doing my gall bladders, pelvic surgery, appendixes, hernias and other simple surgery with a senior man present over the previous five years. I then completed the program and at the end of the period was not advanced to qualified privileges.

"I followed diligently through after this notification, and requested personally to appear before our surgical and gynecological committees to hear the reasons. In spite of the embarrassment of this procedure, there was no reason given other than perhaps a personal one, on the part of some of the surgeons, in which they felt that I had not shown proper humility in requesting help from surgeons who limited themselves to that field. No criticism was made of diagnosis, technic or results in my cases. I am going to apply again this year for the privileges that I feel I justly deserve, having done perhaps 150 major surgical procedures in the hospital over the eight-year period. I was assured by the committee that my surgery had been acceptable but each member who was a surgeon expressed himself to the point that he thought general practitioners should no longer do any surgery.

"I am presenting my own case because I feel it is the most flagrant example of what has happened here. None of the younger surgeons have any opportunity whatever of advancing further in the surgical department. I might also state that a year ago the training program was discontinued by the surgeons themselves."

This doctor's experience is typical of a situation of frustration found in all sections of the country. Few will argue the point that he has performed more major surgical procedures than many board qualified young men emerging from long surgical residencies. One is forced to raise the question as to whether these young board qualified graduates have been prepared as adequately by their four or five years of training as was this generalist, with six years of surgical experience in a smaller community, eight years in his present city, 50 assists, 50 operations done by himself under supervision, and a total of 150 majors, together with the experience of 14 years of general practice.

On the other hand, one must admit there may be valid reasons why he has not been accorded privileges. It must be recognized that in some of these alleged cases of arbitrary discrimination another side to the story may cast a different light on the question.

A Virginia correspondent sums up the results to be expected from such a system as is developing in our hospitals as follows:

"It is not true nor is it reasonable to state that general practitioners expect to do all of the complicated procedures which might be expected of one limiting himself to the special fields, and it is incontestable that all sincere specialists recognize self-imposed limitations within their own specialty. If this be true one must accord the general practitioner the right to the privilege of handling those conditions within a field in which he is experienced, and in which he has demonstrated his ability to the satisfaction of his local colleagues.

"I am opposed to improper, unnecessary, unsupervised medical practice as are my specialist colleagues. Nevertheless, it is my sincere conviction that the situation currently being created by the specialists in exaggerating the complexity of modern medical care, which is aided and abetted in a material way by the exclusion of the general practitioner who would otherwise serve as a leavening influence, is the primary circumstance responsible for the trend toward socialization of our profession."

One Florida doctor, in describing the sudden revocation of his surgical privileges, comes to this succinct conclusion: "Investigation and action by the American Medical Association is the only hope of correcting this unfair situation."

Miscellaneous Restrictions

The survey also revealed complaints of restrictions of generalists in anesthesia and pediatrics, as well as indirect discrimination by denying beds for patients. Very few such complaints are found in this survey, although some are very pointed.

One doctor tells a story of one of his general practitioner confreres who was refused privileges in anesthesia in a hospital in North Carolina. The doctor then took a full year's residency in anesthesia in order to qualify. On completion of his residency he reapplied, and was told he could administer anesthesia if he would give up his general practice of medicine, obstetrics and pediatrics in that hospital. In this case it is very difficult to understand why or how privileges in these three departments would reduce the physician's capacity as an anesthesiologist. The trend toward rigid departmentalization in hospitals and the elimination of the generalist as a hospital staff member is here again demonstrated.

Three physicians in one state object to having public funds (Hill-Burton) used for the benefit of a minority of the population and for the express and exclusive use of a specialty group. They have been excluded from the practice of pediatrics in a children's hospital, which restricts its staff to pediatricians. They point out that 81 per cent of all children in the county are treated by generalists (board of health figures), and that this hospital, built with public

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funds, is operating as a closed staff institution for the benefit of the remaining 19 per cent of the children. They add: "The evasions and methods of excluding generalists are too numerous to mention."

Restriction of beds for generalists comes in for criticism in Pennsylvania. One doctor reports: "In 1951, this hospital announced to its courtesy staff that there would be no more beds available to them. Since courtesy staff included practically all the generalists and only a few specialists, it was an effective way of ousting the general practitioner without appearing to discriminate."

Exclusion of the general physician from the emergency room because he is not a surgeon is recounted by a member of the staff of another hospital. Three sutures were required on an industrial case. The physician transferred the case to his office.

Practitioners Excluded

There are many areas in the United States in which the general physician enjoys hospital privileges in his own general practice department, and in all the specialty departments in which he qualifies. Physicians in these fortunate circumstances can conceive only with great difficulty the predicament in which other generalists find themselves —with no hospital affiliations, and unable to obtain any. This situation, nevertheless, does exist.

An officer of an eastern chapter of the Academy lists nine hospitals in the state which exclude completely any generalist on the staff, active or courtesy. Another respondent lists 23 hospitals in another state which do not allow a generalist on their staffs.

From Pennsylvania comes a report that after serving 18 months in the medical outpatient clinic with understanding that medical staff privileges would be granted after 12 months, a general practitioner was accorded only courtesy privileges in obstetrics and none in medicine or minor surgery.

An applicant was denied any and all privileges in a hospital in Oklahoma. This physician had applied for privileges in general practice, to include no surgery. He says, "After four and a half months, I have been unable to learn the cause of my rejection."

Another in Pennsylvania was refused staff membership, "because we do not accept general practitioners." He applied at another hospital and was told, "No privileges for general practitioners unless they have served internship or residency on the staff of this hospital." This man was thus excluded from both hospitals, not for reasons of professional incompetency, but because he was a generalist.

In Oklahoma, an application for staff membership was rejected because, "We do not have a department of general practice."

No physician can practice modern medicine without access to hospital facilities. Regardless of the interpretation one may make of these individual experiences of generalists throughout the country, it is impossible to escape the conclusion that the general practice of medicine in hospitals is doomed to extinction if present trends in some hospitals are allowed to flourish and expand. The corollary thereof will be either the death of general practice as an institution, with all patient care being administered by specialists, or the development of two distinct classes of physicians in America: the superior who will practice in hospitals, and the inferior who will have no connection with hospitals. It requires no prophet or crystal-ball gazer to reach such a conclusion; the handwriting is on the wall for all who care to face the facts.

If complete departmentalization of service in hospitals, with each physician restricted to a single department and generalists totally excluded from hospital practice is the goal, then let the American Medical Association so declare, and let us proceed with all speed to its realization.

However, if the general practice of medicine is to continue to exist as an institution, with constantly improved standards, with benefit of daily educational contact with specialist confreres through hospital affiliation, the policies of arbitrary restriction and exclusion of generalists as a class must cease. The decision is one for the American Medical Association to make. The task is a complicated one. It must start with medical education and proceed up into the field of hospital relationships.

The A.M.A. Council on Medical Education and Hospitals currently reports that only five of 81 medical schools are sponsoring rotating internships specifically designed for general practice. Eight are aiding in developing residency programs in general practice. The report of the council states:

"It is believed by many that there is a need for a modern definition of what should constitute general or family practice as it confronts the young physician of today. If this can be accomplished there is need for cooperative planning on the part of the medical schools, hospitals and professional organizations in the formulation and implementation of graduate programs designed to furnish the background essential for the physician planning to enter this field. The broad challenges and needs for preparation in the field of general or family practice have, in the opinion of many thoughtful individuals, been allowed to go by default as those in the narrower specialty fields have received greater attention."

It is obvious from this statement of the council that the seriousness of the problem is appreciated by the specific agency of the A.M.A. supervising medical education. It seems that the next logical step would be for the official policy making body, the house of delegates, to take an official stand, and direct that steps be taken to correct the admitted deficiency.

The editor of the *Journal of the A.M.A.* also faces the facts of the case when he says:

"The planning and development of genuinely adequate programs of graduate education for those who choose to follow the field of general or family practice has not generally received such meticulous attention on the part of medical educators. . . . Trends in specialization will not eradicate in the foreseeable future needs for well qualified and highly competent personnel in the field of general or family practice. Is it not time, therefore, that every effort should be made to assure the same high standards of preparation for 'specialists' in this important field as have been given to the preparation of personnel in the narrower specialties? Such developments will involve analysis of the current needs and definition of the scope of general or family practice today and its potential future in order to design graduate educational programs of maximum value."

The Trend Toward Sheer Science

Cognizance of the urgency of the problems of general practice is not limited in A.M.A. circles to the Council on Medical Education and Hospitals, and the editor of the *Journal*. The special committee of the house of delegates on general practice experience prior to specialization has had this to say:

"If the present trend in medical education and training continues toward sheer scientific medical practice and the pendulum is not made to swing back, the art of medicine will be a dead art in another 50 years; doctors of medicine, like veterinarians, will be treating homo sapiens as just another animal without soul or spirit."

Another A.M.A committee, the committee on medical practices, after investigation in an entirely separate field, recommended as a solution to purely ethical problems the discouragement of arbitrary restrictions by hospitals against generalists as a group regardless of their qualifications as individuals. At its meeting in Boston last month, the house of delegates approved this recommendation.

Reinforcement of this opinion comes also from without the circles of organized medicine. Dr. Robert A. Davison,

who is head of the department of general practice at the University of Tennessee, says this:

"I have a strong feeling that the lack of interest in students going into general practice is based not so much on their personal desires, but on the fear that hospital facilities will not be available for them if they are general practitioners. I think it quite certain that the exclusion of general physicians from hospitals is widespread. This has a definite effect on the quality and cost of medical care. One of the important facets of postgraduate learning of the family physician is his exposure in the hospital to his fellow general physicians and specialist colleagues. The continued educational value of hospital privileges cannot be overemphasized."

From other areas, nonteaching and nonofficial, come the pleas for action. Dr. Max L. Lichter, writing on the editorial page of the *Detroit Medical News,* says in discussing the growing tendency of hospital organizations and administrations to be the judges of medical competence:

"The reason behind all this, we feel, is the senseless assault upon general practice by some of our colleagues with special interests. It is the same old fiddle, just different strings are being played. Thus the policies under the guise of improving medical care are designed to restrict general practitioners, ultimately doing away with them entirely and bringing about a new form of medical practice. A great disservice is done to medicine because these special views are not compatible with the best interests of the future. This, we feel, is a serious mistake, which some day will cause much wailing and gnashing of teeth by those who now propound it. . . . It is inconceivable that destroying the dignity of a large percentage of the members of our profession and bringing about their eventual abolition by restrictive and derogating imposts will result in better medical care for the American public. Rather, it would be good sense to encourage our general practitioners to become good and better family doctors, something which our patients want and for which many of our special friends have no particular taste."

The evidence here presented leads to six conclusions:

1. The education of medical students, interns and residents for the practice of general medicine is deficient.

2. In many sections of the country the generalist is the victim of restrictions in hospital practice highly inimical to the interests of good medical care of the American people.

3. This increasing restriction is contributory to the growing shortage of generalists and the increasing surplus of specialists.

4. Arbitrary restriction and exclusion of generalists as a class without opportunity for greater participation in hospital practice based on individual professional capacity tend to lower the quality of medical care by depriving the generalist of the continuous medical education inherent in daily hospital contact with his confreres—both generalist and specialist.

5. The problem of integration of the generalist into the hospital staff organization throughout the country is properly a problem for the entire medical profession, and can be accomplished only by the American Medical Association.

6. The American Medical Association should take immediate steps leading to solution.

Specifically, how will this be done? The house of delegates of the A.M.A. cannot dictate policies to medical schools; it cannot dictate to a hospital board. But to underestimate the influence of the A.M.A. in these fields is sheer folly.

The American public, the consumers of medical service, look to the American Medical Association for the solution of all the country's medical problems—and rightfully so. In the absence of such solutions, the ever-ready substitution of government control of medical services is tendered annually by those who would capitalize on our failures and our shortcomings.

Evaluation and Treatment of Amoebic Infections

MOST of the important discoveries in microbiology have been achieved in the relatively recent years. However, the genuine foundations of this field of science actually had been laid almost three centuries ago.

Using a very low power lens, Kircher observed living entities in putrid meat as early as 1659.[1] Dobell[2] reports that Leeuwenhoek was the first man to see living protozoa; the year was 1674. Parasitic amoebae were first described by Gros[3a] in 1849. The first observation of intestinal amoebae (suspected to be E. coli) was made by Lewis[3b] in 1870, and Lösch[3c] is considered to be the first one to report information on E. histolytica (1875).

In the United States, the first communication on amoebiasis was written by Osler[3d] in 1890 and was followed shortly by the classical paper of his colleagues Councilman and Lafleur[3e] in 1891. Councilman and Lafleur are responsible for the definition of amoebic infections as a pathological entity, and the introduction and characterization of the terms "amoebic dysentery" and "amoebic abscess of the liver."

Etiology. Man is parasitized by six species of amoebae, namely: Endamoeba coli, Endolimax nana, Iodamoeba buetschlii, Endamoeba gingivalis, Dientamoeba fragilis and Endamoeba histolytica.

Rentdorff and Holt[4] have confirmed recently the general belief that I. buetschlii, E. nana and E. coli produce only innocuous infections. They reported that experimentally infected volunteers did not complain of gastrointestinal symptoms nor did they show clinical illness which could be associated in any way with the experimentally induced infection.

E. gingivalis is known to parasitize the mouth of man. The frequent presence of these protozoa in pyorrheic lesions is reportedly[5] not due to any invasive power; they are considered to be scavengers of diseased tissue. Although it was thought of some time ago as the etiological agent in pyorrhea alveolaris and even tonsillitis, the pathogenicity of the organism was never established. The only danger associated with these protozoa is their strong morphological resemblance to E. histolytica. Sultiff, Green and Sutter[6] caution that E. gingivalis is able to establish itself in the bronchial exudate and could be mistaken for E. histolytica. They urge diagnosticians to request complete tinctorial procedures in the examination of amoebae found in secretions of the lungs.

Burrows et al.[7] reviewed recently reports of suspected pathogenicity of D. fragilis and presented experimental data substantiating the pathogenic nature of this parasite. They attributed to D. fragilis four cases of localized tissue reactions—fibrosis of the wall—in the appendix. Hughes[8] diagnosed several mild to moderate gastrointestinal disorders due to D. fragilis infection. Administering three times daily 250 mg. of carbarsone for 10 days, concurrently with three times daily 100 mg. of atabrine for the last seven days, he eliminated the organism from the host's system and found improvement in the patients' gastrointestinal functions.

There is no doubt, however, that E. histolytica is the truly dangerous protozoan of the six species of amoebae parasitizing human organs. The infection originates through ingestion of food contaminated with cysts of E. histolytica. The gastric juice and secretions from the small intestine appear to weaken the cyst wall and activated amoebae may emerge from some cysts in the ileum. The trophozoites, depending upon various etiological factors, may or may not invade the mucosa of the large bowel; aided by their cytolytic substances, they may penetrate the intestinal tissues. In some instances, the amoebae will obtain entry into mesenteric venules and the infection may metastasize by way of the blood stream, producing amoebic hepatitis, hepatic, pulmonary and brain abscesses. A considerable number of authentic records indicate that E. histolytica may cause lesions in practically all parts of the human body, even though some infections are so rare as to be considered medical curiosities.

The sources of contamination with E. histolytica are the same as those in many other infectious diseases. The great importance of the food handler in the transmission of amoebiasis needs to be emphasized. Schoenleber[13] reduced the incidence of amoebiasis in a community by 50 per cent in one year and by 90 per cent in three years, treating the local food handlers.

As to the etiology of human infections with this pathogen, one should quote Elsdon-Dew of Durban, South Africa. His experiences in the treatment of amoebiasis, in hospitals admitting individually up to 2500 to 3000 cases of acute ulcerative amoebiasis yearly, may be considered unique. Recently,[9] he raised the questions: "Do we really know what E. histolytica does?" "Is it in fact a definite pathogen, or is it only pathogenic when some other factor determines its pathogenicity?" He also made the statement: "I do not think that E. histolytica is always pathogenic. I do think, under certain circumstances, probably associated with a change in the bacterial flora, following perhaps on a change of diet, particularly a diet of what one might call the lower carbohydrates, the amoebae receive a stimulus to invade. Exactly what the nature of the stimulus is, we do not know. Thereafter the amoebae invade and give us the disease. Without that stimulus the amoebae are unimportant."

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Phillips et al.[10] inoculated intracecally 35 *germ-free* guinea pigs, maintained on identical sterilized rations, with E. histolytica derived from cultures of amoebae with T. cruzi; none of these animals developed amoebic lesions. Inoculation of 37 *conventional* guinea pigs with E. histolytica from the same culture produced in 34 animals acute ulcerative amoebiasis, the remaining three harboring amoebae for a substantially longer period than any of the animals in the first group. Inoculating two series of guinea pigs, *monocontaminated* with E. coli and A. aerogenes, respectively, with E. histolytica from the same source, produced acute ulcerative amoebiasis. These investigators have shown that, in the absence of other microorganisms, the amoebae appeared to be harmless, incapable of independent survival in the intestine; while E. histolytica is the causative agent of intestinal amoebiasis, other microorganisms seem to share the responsibility for the etiology and pathology of amoebiasis. This indicates that the effect of chemotherapeutic agents upon the bacterial flora is more important than certain workers would care to admit and their importance should not be underestimated.

The work of Elsdon-Dew,[11] and Felsenfeld and Comess[12] appears to substantiate the importance attributed to nutritional factors in pathogenic manifestations of amoebic infections. Their studies indicate that a high protein and low carbohydrate diet reduces the number and perhaps the pathogenicity of E. histolytica.

Incidence of Infection. The geographical distribution of amoebiasis was once believed to be limited to the tropics. In his recent book, Faust[14a] expresses the belief that "amoebiasis exists in all native populations of the world from the Arctic to the Antarctic circles." In the Western Hemisphere, amoebiasis was actually found to be indigenous as far north as Alaska and as far south as the Strait of Magellan.[14b] In the United States, Craig and Faust[14c] reported an average incidence of 8.1 per cent, the incidence ranging from 1.4 per cent in New England college students to 36.4 per cent in rural Tennessee. It should be noted, however, that McHardy[15] reported recently a 3.9 per cent incidence of amoebiasis in the United States. His figures are based on reports submitted by institutions and specialists from all states, with the exception of Kansas, Nevada and Vermont. He computed the highest state averages for Alabama (23 per cent) and Mississippi (12 per cent).

Diagnosis. The variation in the percentage figures of the numerous reports on the incidence of amoebiasis results from the difficulty in diagnosing these infections. E. histolytica must be demonstrated in the tissues or feces of the patient to establish a definite diagnosis of infection with this parasite. There is no doubt that this constitutes one of the most difficult diagnostic problems for the parasitologist. Personnel must be given months of constant, thorough training before an individual acquires the skill necessary for the identification and differentiation of the various intestinal protozoa of man. The seriousness of this problem is demonstrated in the publication of Tobie et al.[16] Upon repeated examination of feces of 28 persons, known to be infected with E. histolytica, by personnel having above average skill in the identification of this parasite, using one of the most thorough methods available, 71 per cent of the patients were diagnosed on the first examination, 82 per cent through the second, 86 per cent through the third, 96 per cent through the fourth, and 100 per cent through the fifth. They point out, that, while a considerable number of amoebae may be present in the stool of the infected individual one day, the next day or next week no organisms can be detected.

For an evaluation of the serological factors relative to the diagnosis of amoebiasis, the reader is referred to the work of Bozichevich,[17] and Cole and Kent.[18]

Regarding opinions differentiating between the pathogenicity of small and large species of E. histolytica, McCollough[19] feels that the concept advancing the nonpathogenicity of the small type of this parasite has not been adequately substantiated.

Rationale of Chemotherapy. The treatment of amoebiasis includes a wide range of infections: asymptomatic carriers of E. histolytica, acute and chronic dysentery, various amoebic abscesses and other complications. An ideal chemotherapeutic agent should reach an effective level in the lumen of the intestine and the tissues of the affected organs, challenging the various life-stages of the parasite, without having toxic effects on the patient. There is no drug at the present time which meets *all* these specifications. Considering the entire picture of the current anti-amoebic treatment, the physician has a major task in selecting the most effective chemotherapy. It is difficult to compare one worker's results with another's, because of the variations in the definitions of treatment and criteria of success or failure.

Anderson[20] divides the currently administered therapeutic agents into three major categories: (1) agents acting directly on pathogenic amoebae in the bowel or in affected tissues; (2) agents acting directly on pathogenic amoebae within the tissue only (extraintestinal amoebiasis); (3) agents which act indirectly on the pathogenic amoebae by affecting primarily the bacterial flora. Since it is felt that in most instances no single agent of any individual group is capable of eradicating all phases of amoebic infection, investigators have developed various therapeutic regimes by combining agents of different specificities.

Treatment Programs. Martin et al.[21] have presented an extensive study on the effects of emetine, carbarsone, chiniofon, bismuth glycolylarsanilate (milibis), chloroquine (aralen), chlortetracycline (aureomycin), oxytetracycline (terramycin) and chloramphenicol (chloromycetin). The drugs were evaluated individually and in various combinations in a total of 538 patients with enteric lesions, having mucosanguineous exudates and trophozoites of E. histolytica in their stools. They reported that the administration of oxytetracycline alone, and in combination with carbarsone, chiniofon, bismuth glycolylarsanilate and chloroquine gave the best results. Almost equivalent results are claimed for the chlortetracycline-chloroquine combination.

Emetine, carbarsone and chiniofon combined gave a good initial response, but an appreciable relapse rate, while the application of bismuth glycolylarsanilate combined with chloroquine, and emetine and chlortetracycline administered individually yielded a fair initial response with a high relapse rate. Carbarsone, chiniofon, chloroquine and chloramphenicol, each applied separately, were found to have minimal therapeutic value. It should be noted that follow-up examinations terminated six weeks after treatment.

Radke[22] evaluated six treatment regimes in a total of 222 patients with lesions in the lower intestine, yielding

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E. histolytica positive smears or cultures; a three month follow-up period was observed. Among various combinations of carbarsone, chiniofon, quinacrine (atabrine), chlortetracycline and oxytetracycline, the investigator reported outstanding results with a quinacrine-carbarsone therapy. The treatment involved the administration of 4 x 100 mg. of quinacrine daily for 15 days concurrently with 3 x 250 mg. of carbarsone daily for 10 days. Radke also claims that this combination of drugs has proved effective in amoebic liver and pleuropulmonary infections, eliminating the necessity of surgical intervention.

Singh[23] discusses in his recent communication several treatment programs, applied widely during the last 16 years. From his personal experiences with some of these therapeutic regimes, he developed a system which appears to yield rather satisfactory results in amoebic dysentery. First, he recommends the intravenous administration of loading doses of iron and vitamins, whenever there is the slightest indication for such treatment. Second, he administers 250 mg. of carbarsone, 600 mg. of diodoquin, 200 mg. of chloroquine and 500 mg. of chlortetracycline, simultaneously, three times daily for six days; followed subsequently by 600 mg. of diodoquin and 200 mg. of chloroquine, simultaneously, three times daily for 14 days.

Should there be at this time any residual symptom or sign of infection present, six weeks from the start of the this treatment he administers 250 mg. of carbarsone, 100 mg. of quinacrine, and 500 mg. of oxytetracycline, simultaneously, three times daily for six days. Treating 32 patients with chronic amoebic dysentery, he found only five needing the second course of the treatment. All patients improved rapidly in health upon completion of the treatment. During a three month follow-up, all stools and all occult blood tests were found negative and all ulcers visible sigmoidoscopically were cured. He was able to follow up 20 of his patients for a period of from eight to 24 months and in each of them a permanent cure was indicated. Singh feels that substitution of thiocarbarsone for carbarsone may further benefit the patient.

A current evaluation of the antibiotic picture in the treatment of amoebic infections is presented by McHardy and Frye.[24] Their evalution is based on the efficiency of a single agent rather than on data from a combination of drugs. They computed a 91.5 per cent efficiency for oxytetracycline. Although the results obtained with oxytetracycline are better than those obtained with any other antibiotics or even other amoebacides, they emphasize adequate caution because of significant side effects and reported recurrences. Oxytetracycline is useful in intestinal infections but its value in extraintestinal complications is questioned; Killough and Magill[25] and Martin et al.[21] have actually reported the occurrence of hepatic involvement during oxytetracycline therapy. McHardy and Frye's survey indicates an 86 per cent efficiency for fumagillin. It is considered to be the least toxic of the effective antibiotics; its use is limited to intestinal infections. McHardy and Frye's summary of several reports rates the efficiency of chlortetracycline at 83.4 per cent. They feel that its side effects often contraindicate its use.

The work of Tobie et al.[26] on the comparative effectiveness of mass treatment with oxytetracycline, chlortetracycline and bacitracin, in eradicating E. histolytica, reveals valuable information. In an institution for mental defectives, four infirmaries, each with a population of about 200 inmates, averaging a 56 per cent incidence of asymptomatic or mildly symptomatic amoebiasis, served for the concurrent evaluation of these antibiotics. Each group was treated with one of the three drugs, the fourth serving as untreated control. The following dosages were administered for a period of 10 days: oxytetracycline, 1-2 g. daily; chlortetracycline, 1-2 g. daily; bacitracin, 40,000-80,000 units daily, depending upon the weight of the individual. The investigators report that in the group of 222 inmates treated with oxytetracycline, the incidence was reduced from 49 to 0 per cent, the latter maintained for 2½ months after treatment, a follow-up after six months revealing only a 1 per cent incidence. In the group treated with chlortetracycline, the incidence was reduced from 45 to 0 per cent, the follow-up 2½ months later revealing an 18 per cent incidence. In the group treated with bacitracin, the incidence was reduced from 68 to 28 per cent; the follow-up after 2½ months indicated a 49 per cent incidence. Concurrent checks in the untreated control group showed no incidence of spontaneous cures.

Killough and Magill[27] evaluated the comparative effectiveness of oxytetracycline and fumagillin in a total of 115 patients having symptomatic and asymptomatic amoebic infections. They note that "the presence of secondary bacterial invaders, uncontrolled by fumagillin, may suggest an advantage in the case of oxytetracycline in facilitating the healing of ulcers"; they do not report significant differences between the two antibiotics in parasitological and clinical response.

Elsdon-Dew, Wilmot and Armstrong[28] report that their comparative studies with chlortetracycline and fumagillin in acute ulcerative amoebiasis of African patients indicate the superiority of chlortetracycline. Their findings may find explanation in the fact that the intestinal organs of African natives are heavily invaded with bacterial pathogens.

Seneca[29] found carbomycin (magnamycin) effective in 17 cyst and trophozoite positive patients. The daily administration of 3 x 500 mg. of carbomycin for from eight to 10 days eliminated the infection. Only one recurrence was reported in a follow-up period extending over four to 12 months. Villarejos[30] claims success with erythromycin. The author reports favorable results in the treatment of intestinal and hepatic amoebic infections, with the administration of an 800 mg. initial dose, followed with dosages of 300 mg. every six hours for a period of five days. No significant side effects were observed. Hoegenka and Batterton[31] treated 20 patients (acute amoebic dysentery and relatively asymptomatic infections) with camoform, administering daily 3 x 500 mg. for seven days. In a follow-up period of from three to four months three recurrent infections were observed. The compound appeared to be well tolerated in therapeutic quantities and clinical evidence of drug toxicity was not noted.

While opinions on the chemotherapy of intestinal amoebic infections vary considerably, the majority of workers appear to agree that chloroquine is the drug of choice in extraintestinal amoebic infections. Terry and Spicknal[32] recommend the following schedule for the treatment of amoebic liver infection, the most commonly occurring extraintestinal complication: an initial dose of 900 mg. the first day followed by 300 mg. daily for 20 consecutive days.

Summary. A brief discussion of the current concepts in the treatment of amoebiasis is presented. It is evident that a thorough understanding of the

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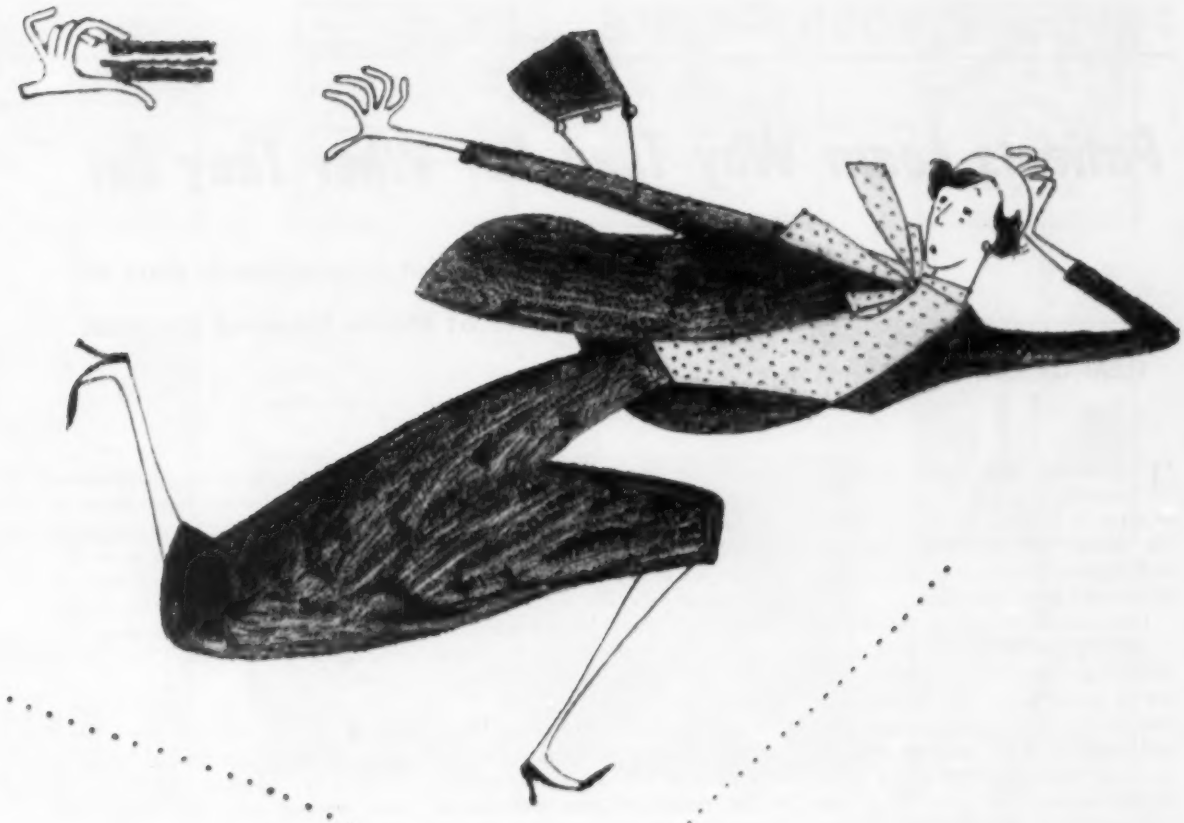

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what's a good

B complex?

sur-Bex® with C

(ABBOTT'S B-COMPLEX TABLETS WITH C)

Each SUR-BEX with C tablet supplies:

Thiamine Mononitrate	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine Hydrochloride	1 mg.
Vitamin B_{12} (as vitamin B_{12} concentrate)	2 mcg.
Pantothenic Acid (as calcium pantothenate)	10 mg.
Ascorbic Acid	150 mg.
Liver Fraction 2, N.F.	(5 grs.) 300 mg.
Brewer's Yeast, Dried	(2½ grs.) 150 mg.

Abbott

As a dietary supplement: 1 or 2 tablets daily.

For stress, or postoperative convalescence: 2 or more tablets daily.

Patients Learn Why They Eat What They Eat

Planned diet instruction is part of the food service at Maine General Hospital

ELEANOR GEE

THE dietary department of Maine General Hospital, Portland, aims to serve its patients in the best possible manner by providing attractive, well balanced meals and by teaching all patients good nutrition.

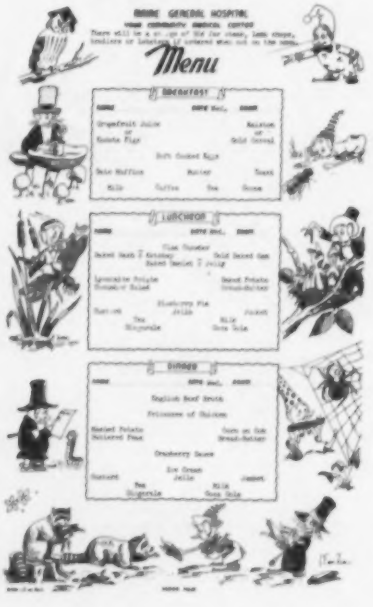
Dietitians introduce all patients to a selective menu shortly after their admission. This includes patients who are on special diets. The dietitian aids the patient in selecting proper food, and keeps in mind that she must be prepared to meet the sensitive needs of each patient. She greets the patient pleasantly each morning and suggests foods that are familiar to him and that will also give him a well balanced diet. Every day until discharge the dietitian aids the patient in selecting meals that are nutritionally sound and explains why he needs his pint of milk a day, his vegetables, salads and fruits. She cautions against improperly balanced meals with too many starches, such as spaghetti, potato and bread, at the same meal. She explains to the patient on a liquid or soft diet *why* he is on that diet and why he should choose nourishing foods if he is to maintain body weight.

The dietitian works with the doctor in the planning of special formulas which can be tolerated by the patient. In her teaching of good nutrition she always keeps in mind the patient's eating habits, his financial and family background, especially if he is on a special diet. A patient accustomed to Italian food, for example, is not going to be happy on a diet of unfamiliar food. Again, the patient who is in the habit of eating a very light breakfast, probably low in protein as a great many of our surveys have shown, is not going to change his eating habits overnight. However, if it is brought to his attention why he should eat better balanced meals and the reasons are explained then the time spent with this patient can change his eating habits.

For the patient on a special or therapeutic diet the hospital has its own diet manual. This manual, compiled in 1951 by a committee of the medical staff working with the dietary staff, has minimized and standardized the ordering of special diets. Twenty-five per cent of Maine General Hospital's patients are on special diets; thus a great deal of instruction is given daily to this group. If the doctor orders a low residue diet, for example, the dietitian goes over the diet with the

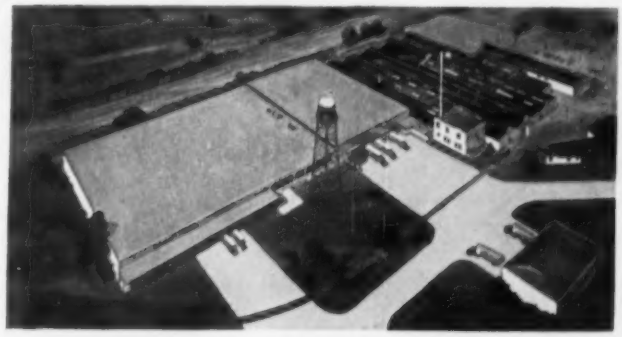
Mrs. Gee is director of nutrition, Maine General Hospital, Portland, Maine.

Left: Patients are given booklets that help them keep to their diets. In addition, the hospital has prepared its own "Diet Manual."



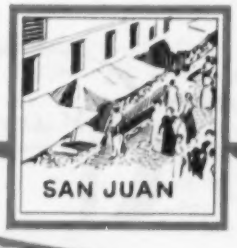
Right: From these cheerfully illustrated menus patients select the proper foods with a dietitian's help.

America's only National Chain Wholesale Grocers, offering all of the economical advantages of the chain while preserving every single feature of service that has stood for pleasant customer relationship in seventy years of specialized service to the institutional market.



SEXTON PARK IN INDIANAPOLIS, HOME OF SEXTON'S "SUNSHINE KITCHENS"

Through the company's world wide resources and in its modern experimental laboratories, many earned firsts have accrued to reward the company. Its steadfast purpose to handle only quality food likewise has been rewarded because there can be no true economy in food where the consideration of quality is not paramount.



Sexton
Quality Foods

JOHN SEXTON & CO., CHICAGO, 1956

patient and gives him a printed copy of the diet so that he knows what to expect and the reasons for the food served on this diet. This procedure in the long run saves the dietitian's time, for the patient now knows what he may have to eat and why. If the diet order is later changed to a bland diet he then receives a copy of that diet, and so on until he is ready for discharge.

Patients on low calorie diets are told just what foods they can eat and why they may not have cake or high caloric pastries. It is explained that they may have only a certain number of calories for the day; that certain foods essential to maintain life must take a lead position in the day's allotment of calories so that the patients will not suffer from diseases arising from the lack of protein, minerals or vitamins.

So many patients say, "But all I ever eat for breakfast is a doughnut and a cup of coffee. These cannot have too many calories." This is true but these people do not realize that such a breakfast is inadequate in other respects; it is lacking in vitamins, minerals and protein and they are not getting the benefits of a good breakfast which they need. Patients on low purine diets, low sodium diets, modified ulcer diets and low fat diets also have to be taught the reasons they should eat the foods on the diet pre-

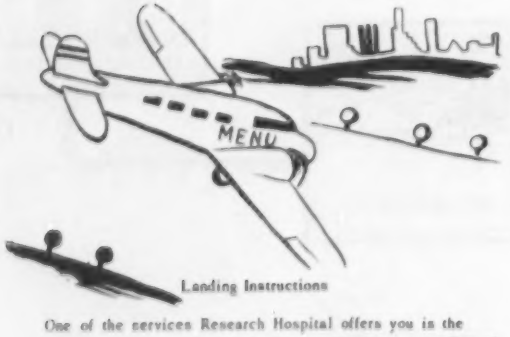
DIET MANUAL GIVEN PATIENTS AT RESEARCH HOSPITAL, KANSAS CITY, MO.

Research Hospital Kansas City, Missouri

Wake up with a smile – – –
Breakfast is served from
7:30 AM to 8:45 AM

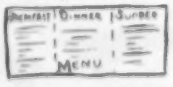
To satisfy the middle of the day hunger – – –
Dinner is served from
11:30 AM to 12:30 PM

To carry you through the night – – –
Supper trays are served from
4:45 PM till 5:30 PM



Landing Instructions

One of the services Research Hospital offers you is the opportunity of selecting your own.



This opportunity cannot be extended to persons on modified diets. Each morning a Research Hospital hostess 

will assist you in choosing your meals for the next day.

Place a check mark (✓) to the left of each item you desire. Indicate by number if you wish more than one serving of a given item. Example: ✓ Coffee 2 Coffee Cream 3 Sugar Packets ✓ Butter.

64 PERFECT CHEESEBURGER SLICES WITH ONLY 3 KNIFE CUTS... Kraft Ribbon Slices!

THE portion-control answer to profitable cheeseburger sandwiches are Kraft Ribbon Slices. Here's top-quality pasteurized process American Cheese actually *made in slices!* With only 3 knife cuts you get 64 perfect ¾-oz. cheeseburger slices in a matter of seconds. That's an average of 21 slices per pound!

Compare this to the time-consuming job of slicing loaf American Cheese by hand or machine—you realize only about 16 slices per pound and are bound to have waste in the form of slivers and broken pieces. What's more the slices won't be uniform in weight.

In contrast because each Ribbon Slice is a perfect portion—uniform in size, shape and weight—you can measure your costs to the penny! Be sure to order Ribbon Slices from your Kraft Institutional Representative the next time he calls!

Perfect portion-control slices in a jiffy

A with three knife cuts on red lines on package, you get 64 ¾-oz. cheeseburger slices.

B with two knife cuts on blue lines on package, you get 48 1-oz. sandwich slices.

KRAFT Foods Company INSTITUTIONAL DIVISION

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500 Peshtigo Court • Chicago 90, Illinois

THE NATION'S TASTE IS YOUR BEST BUYING GUIDE

scribed for them. For example, a patient on a modified ulcer diet may not be getting the proper amount of vitamin C (ascorbic acid) from the diet as prescribed by the doctor. This is especially true when the patient cannot tolerate albuminized orange juice or other foods rich in ascorbic acid which normally are restricted on this diet. In this case supplementary ascorbic acid tablets are usually prescribed by the doctor.

At Maine General Hospital we have weekly diet conferences to discuss patients who are on special diets. The five dietitians, two dietitian aides, and five student nurses plus student dietitians when on duty attend these conferences. Financial situations, family environment, former food habits, patient's attitude toward present diet, whether or not the patient will follow his diet at home, and the prognosis are discussed. Caloric intakes are calculated on patients who are on high caloric diets and also on patients who suffer from anorexia to determine if they are consuming the required amount of calories as prescribed.

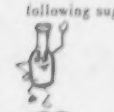
The teaching of the clinic patient is another of the duties of our dietary department. Dietitians are called upon to instruct patients on low salt diets, modified ulcer diets, prenatal diets, diabetic diets, and so forth. As our outpatient clinics continue to grow—we now have 18,000 visits per year—a full-time clinic dietitian is needed for the instruction of outpatients.

The child patient on a special diet, if old enough, whether in the hospital or in the clinics, is instructed by the dietitian but usually she instructs the mother. If the family's income is low the dietitian must have knowledge of low calorie recipes high in vitamins and minerals and the other necessary food constituents which will fit into the fam-

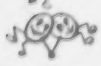
RESEARCH HOSPITAL'S MANUAL HELPS TO MAKE DIET INSTRUCTIONS PALATABLE

In order to successfully complete our journey we will make 3 daily stops for refuel.

Be very particular about your choice of fuels. May we offer the following suggestions:



MILK:
2 or more servings daily – as a drink or in soups, custards, ice cream, or pudding



EGGS:
One daily or at least 3 to 4 a week

MEAT:
2 servings or 1 serving meat and 1 serving cheese, peanut butter, dried peas or beans, or a second serving of eggs

VEGETABLES:
2 or more servings brightly colored (one to be leafy green or yellow)

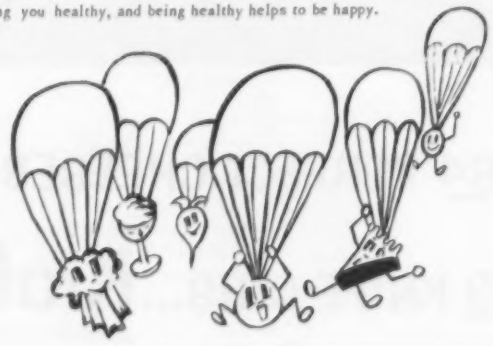
POTATOES:
1 serving daily

FRUIT:
2 servings-(one to be orange, tomato or grapefruit)

BREADS OR CEREALS: (whole grain or enriched)
3 or 4 servings daily

BUTTER OR FORTIFIED MARGARINE:
4 teaspoons daily

We have suggested this plan of eating while in the hospital; continue to eat in this manner after you go home. This meal plan will also be of benefit to your family. It will reward you by making you healthy, and being healthy helps to be happy.



When your doctor orders a special test, your tray may be delayed or omitted entirely.

Cheer up, the dietitians aren't trying to starve you! You will receive a meal when the test is completed.

The dietitian will instruct you if you are to follow a modified diet when you go home. These instructions are given when your doctor orders them. If you want plenty of time to learn and a great deal of attention, ask him about an early instruction. Learning a diet while sitting on your suitcase isn't pleasant.

HOW HEINZ KETCHUP GETS ITS CAN'T-BE-COPIED FLAVOR

1 To get tomatoes good enough for Heinz Ketchup, we had to develop our own private strain on our Heinz experimental farms. Here they're checked to make sure they were at the peak of ripeness when picked.

2 The spices are weighed and blended, following Heinz secret, time-tested formula. The vinegar and sugar are carefully and accurately measured in. The onions, mild Californians only, are added.

3 We take our time cooking it down—for you can't rush good ketchup. And the results in batch after batch—thick, deep red and savory—are assured by Heinz know-how. The skills of our 50 years of ketchup making can't be matched overnight.

4 Make sure the can't-be-copied flavor of Heinz Ketchup is working for you. Served as a condiment or cooked into the dish, Heinz does more for food than any other ketchup. For the difference it makes, the cost is trifling. Order the famous 14-ounce bottle or #10 tin.

HEINZ 57 KETCHUP

YOU KNOW IT'S GOOD BECAUSE IT'S HEINZ

ily budget. She teaches the mother to use foods such as dry skim milk powder, low cost cuts of meats, fruits and vegetables in season, and to avoid buying luxury items such as pineapple juice. If a family is on city or state welfare and certain high cost items are essential the hospital's medical social service department acquaints the patient's caseworker with the facts and necessary arrangements are worked out.

In the instruction of patients on low sodium diets we use printed booklets which give the sodium content and caloric value of common foods. These booklets have been quite successful. Not only do they aid the patients but they cut the teaching time of the dietitians. The patient is given a booklet as soon as he is placed on the diet. When he is ready for discharge he has become familiar with the foods and the amount of each he may have. Thus, when he goes home his diet is not too difficult for him to understand. Many families who have a member on a low sodium diet cook all of their food without salt, permitting those who may have salt to add it at the table. This makes the patient feel that he is not set apart from the family group.

Gone are the days when people who were on special diets were made to feel "left out." Today all of our special diets are based on the normal or house diet. Whenever possible our doctors allow the patient enough sodium to permit the use of ordinary skim or whole milk. Proprietary dialized milks (from which sodium has been removed) are expensive, not too palatable, and frequently cause the patient to break his diet. Some patients who do not care for these dialized milks will omit milk entirely and thus not get the required amount of protein and calcium.

Quite frequently the dietitian meets opposition from the patient regarding his diet. Many uneducated patients have poor dietary habits, such as little or no breakfast, lots of starches, very few vegetables and fruits, and inadequate protein. Since they have never enjoyed really good health, they do not know or care what good health is. It is difficult to instruct such patients for many only spend an average of five days in the hospital and do not care to change their food habits. All that our dietitian can do in such cases is to give the patients all the material she has available on good nutrition and the daily basic seven food facts and hope they will be interested enough to try it out. It is the dietitian's duty to educate the patient toward improving his eating habits for better health.

Patients are taught that they should eat a breakfast adequate in protein in order to maintain the blood sugar at or above the fasting level. Numerous patients state that they cannot drink milk as plain milk. We try to educate these patients to take their milk in chocolate milk, in eggnog, in cheese, in cream soups, or in puddings.

Today we are stressing more and more the teaching of nutrition to student nurses on the nursing floors close to the patients. This is carried out by the instructor in nutrition and dietetics and the student nurse. It gives the student a firsthand opportunity to observe the nutrition instructor teaching the patient. The student nurse has an opportunity to aid in planning patients' meals and trays, in checking their caloric intake, and discussing nutritional needs with the nutrition instructor.

The diabetic patient, especially the one on insulin, requires a great deal of dietary instruction. At Maine General Hospital we use two types of diabetic diets, since some of the older staff members are still prescribing the diabetic diet which calls for the use of the 5 per cent, 10 per cent, 15 per cent fruits and vegetables, while others are prescribing the diabetic diet based on the "Meal Planning and E change Lists."

The former calls for more individual attention and is more difficult for the patient to understand but once the patient learns how to calculate his own diet it permits a less monotonous diet and he can readily work out his own daily menus. This diet also gives the doctor an opportunity to prescribe fairly accurately the number of calories he wants his patient to have.

The "Meal Planning and Exchange Lists" system is easier for most diabetics since it tells them exactly what they can plan for each meal and no calculation is necessary. It gives them meat, bread, vegetables, fruits and fat substitutions. One drawback of this diet is the substitution of milk, for some patients cannot tolerate milk and it is necessary for the dietitian to change the whole planned diet in order to make up for the omission of milk and to balance the carbohydrate, fat and protein. Since the primary purpose of treatment is to attain and maintain health through good nutrition, the use of artificial supplements or additives to the diet such as capsules and pills

New Food Conveyor Brings You These Advantages of Selective Menu Service

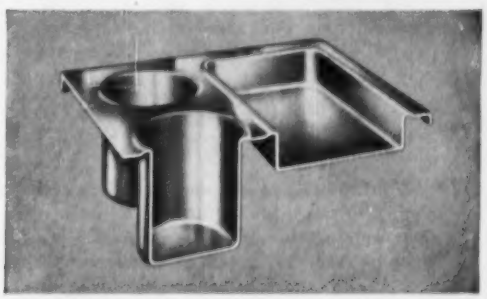
- Patients Enjoy Food
- Meals Are More Palatable
- Menu Has Greater Variety
- Less Food Is Wasted
- Elevator Loads Are Reduced

EVERY DAY more hospitals are learning the "Selective Menu" lesson. The experience of many institutions proves that providing a choice of foods and getting them to the patient in palatable form has important advantages. For one thing, patients' morale is improved and recovery is speeded. There's more appetite appeal, less food waste, greater satisfaction with your hospital's service.

ONE CONVEYOR, MANY TOP ARRANGEMENTS — The Blickman "Selective Menu" Food Conveyor has been specially designed to provide a variety of foods for selective menus. It is built entirely of stainless steel. Square and rectangular pans, furnished with each conveyor, can be arranged in different ways within each of the two rectangular wells. Combinations can be varied according to the food requirements for any given meal. Since it transports food in bulk, fewer trips are required, reducing elevator use considerably during mealtime.

NEW, SEAMLESS, SANITARY TOP — The "Selective Menu" Food Conveyor also achieves high standards of sanitation with the new crevice-free, sanitary top. All surfaces are smooth and continuous where wells meet the top deck. Thus dirt-collecting traps around wells found in ordinary construction are entirely eliminated. Why not investigate the unusual features of this new conveyor now? . . . Write for helpful booklet.

CHOOSE the top deck arrangement needed for any specific menu. Variety of sizes in square and rectangular insets permits flexibility in accommodating a number of vegetables, meats, fish, potatoes, soup and broth.



SEAMLESS, crevice-free, sanitary top—all wells are part of the top deck, forming smooth, continuous, crevice-free surfaces where they join the top. Cleaning is simple and quick.

"Selective Menu" Food Conveyor at Stamford (Conn.) Hospital. Nurses carry trays from diet kitchen to patients with food that is hot and appetizing.

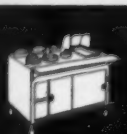
Send for Catalog

Send for helpful descriptive literature explaining merits of the "Selective Menu" and describing this and other Blickman-Built Food Conveyors.

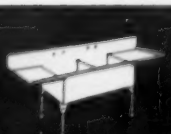
S. Blickman, Inc.,
1501 Gregory Avenue, Weehawken, N.J.

Blickman-Built
FOOD SERVICE EQUIPMENT


COFFEE URNS


STEAM TABLES


FOOD CONVEYORS


SINKS


WORK TABLES

You are welcome to our exhibit at the Association of Operating Room Nurses Convention, Hotel Statler, Boston, Mass., Booths 28 and 29, Jan. 30-Feb. 1.

are discouraged whenever possible. Patients are spending a great deal of money unnecessarily, for some of these preparations contain ingredients purporting to contain vitamins and minerals for which no physiologic need has yet been demonstrated. Also, patients are inclined to cut down on their necessary food nutrients when taking these additives. Additives for the patient on a special or therapeutic diet, when necessary, come under the doctor's prescription.

The picture on this month's cover of The MODERN HOSPITAL shows a Maine General dietitian instructing the patient on a diabetic diet. Notice the gram scales which are used in our hospital. Some of the doctors request that their patients be taught to weigh their diets in the hospital and even at home. This patient is being instructed how to weigh the foods in amounts necessary for a balanced meal. She is taught substitutions and, whenever possible, how to calculate her own diet. Most of these patients are taught not only how to weigh their food but also how to use household measures in planning their menus.

As yet we do not have a planned program for the classroom instruction of diabetics. This is one of our aims and is provided for in the new Maine Medical Center now under construction here. Classroom instruction will give the patient many advantages. More displays and exhibits will be used, more time will be allocated for classroom instructions, families can attend at the same time, and patients will maintain a higher personal interest in class instruction.

If only there could be more of a community nutrition teaching program! Through this channel groups in the community and special groups, such as obese people, pregnant women and mothers, and others who need guidance, would be educated in better nutrition. Then when they became patients in the hospital they would be able to choose their foods more wisely and would be able to understand the reasons they must eat certain foods when on a special diet.

We at Maine General Hospital are striving to continue to teach patients better nutrition and realize that only through good, balanced meals served attractively at the right temperature within the budget allotted the department and through harmonious dietitian-patient contact will the dietary function efficiently.

Menus for February 1956

Velda Milbrot
Administrative Dietitian
Misericordia Hospital
Milwaukee

1 Stewed Prunes French Toast, Sirup • Consommé Liver and Bacon Mashed Potatoes Buttered Peas Waldorf Salad Cottage Cheese Torte • Cream of Spinach Soup Spaghetti and Meat Balls Frozen Spinach, Lemon Wedge Green Salad, French Dressing Fruit Cup	**2** Orange Juice Sausages, Toast • French Onion Soup Ham Loaf, Horseradish Sauce Escalloped Potatoes Baby Lima Beans Golden Glow Salad Vanilla Ice Cream • Chicken Rice Broth Corn Fritters, Sirup Canadian Bacon Peach Cup Salad Spice Cake, Orange Icing	**3** Grapefruit Half Soft Cooked Egg, Toast • Celery Broth Fried Perch, Tartare Sauce Parsley Buttered Potato Green Beans Stuffed Prune Salad Lemon Meringue Pie • Cream of Tomato Soup Toasted Cheese Sandwich Buttered Mixed Vegetables Banana-Orange Salad Chocolate Pudding, Whipped Cream	**4** Pineapple Juice Scrambled Eggs, Toast • Egg Drop Soup Beef Stew in Casserole With Biscuit Coleslaw Baked Apple, Whipped Cream • Cream of Asparagus Soup Salisbury Steak, Mushroom Sauce Baked Potato Fruited Gelatin Salad Oatmeal Cookies	**5** Orange Juice Sweet Roll, Bacon • Blended Juices Roast Turkey, Dressing Cranberry Sauce Mashed Potatoes Broccoli With Buttered Crumbs Lettuce, French Dressing Chocolate Sundae • Beef Noodle Soup Pea, Cheese, Pickle Salad Potato Chips, Liver Sausage Nut Bread Canned Pineapple Chunks	**6** Grapefruit Juice Soft Cooked Egg, Toast • Chicken Rice Soup Roast Beef, Gravy Oven Browned Potato Green Beans Pickled Apple Salad Frozen Peach Shortcake • Vegetable Soup Escalloped Potatoes and Ham Buttered Beets Green Salad, French Dressing Corn Muffin Prune Whip, Custard Sauce
7 Orange Halves Poached Egg, Hard Roll • Beef Barley Broth Pork Chop With Applesauce Mashed Potato Buttered Squash Cabbage, Carrot, Raisin Salad Apple Pie • Potato Chowder Spanish Rice With Bacon Buttered Wax Beans Asparagus Tip Salad Fresh Fruit Cup	**8** Stewed Apricots French Toast, Sirup • Consommé Meat Loaf, Ketchup French Fried Potatoes Frozen Spinach With Lemon Wedge Peach Salad Raspberry Bavarian Cream • Cream of Spinach Soup Mock Drumsticks, Gravy Baked Potatoes Stuffed Celery Oatmeal Cookies, Canned Apricots	**9** Orange Juice Scrambled Eggs, Bacon • Beef Noodle Soup Veal Cutlet With Spiced Pear Escalloped Potatoes Buttered Carrots Perfection Salad, Mayonnaise Vanilla Ice Cream • Split Pea Soup Cheeseburger on Bun Buttered Asparagus Tossed Salad Date Torte, Whipped Cream	**10** Grapefruit Half Raisin Toast, Jelly • Vegetable Broth Fried Pike, Tartare Sauce Parsley Buttered Potato Frozen Peas Prune-Mandarin Orange Salad Pumpkin Pie • Cream of Mushroom Soup Cheese Soufflé With Tomato Sauce Braised Celery Apricot-Cherry Salad Baked Apple With Cream	**11** Tomato Juice Soft Cooked Egg, Toast • English Beef Broth Swiss Steak, Gravy Mashed Potatoes French Green Beans Banana-Peanut Butter Salad Tapioca Cream • Chicken Noodle Soup Chopped Beef Patty, Onion Gravy Baked Potato Lettuce Wedge With French Dressing Canned Plums, Wafers	**12** Grape Juice Sweet Roll, Sausage • Pineapple Juice Baked Ham Candied Sweet Potatoes Cauliflower au Gratin Molded Fruit Salad Strawberry Sundae • Star Broth Macaroni Salad New England Ham, Swiss Cheese Stuffed Olives and Carrot Curls Pear Cream Cheese Salad Angel Food Cake
13 Grapefruit Juice Soft Cooked Egg, Toast • Chicken Rice Soup Roast Pork, Applesauce Mashed Potatoes Green Peas Tossed Salad, French Dressing Whipped Cherry Gelatin With Custard Sauce • Beef Broth Spaghetti and Meat Balls Green Beans Beet and Onion Salad French Bread Canned Apricots	**14** Orange Halves Bacon, Hard Roll, Jelly • Beef Barley Broth Liver and Bacon Escalloped Potatoes Buttered Asparagus Lettuce Wedge With Chiffonade Dressing Blueberry Pie • Vegetable Soup Escalloped Corn With Pork Links Peach Cottage Cheese Salad Valentine Cupcakes	**15** Stewed Mixed Fruit French Toast, Sirup • Tomato Broth Baked Halibut, Lemon Wedge Potatoes O'Brien Harvard Beets Coleslaw Fruit Cup • Cream of Mushroom Soup Cream Cheese Sandwiches Shoestring Potatoes Pickle Chips, Ripe Olives Buttered Squash Citrus Fruit Salad Chocolate Drop Cookies	**16** Orange Juice Scrambled Eggs, Toast • Beef Broth Turkey Fricassee on Rice Buttered Spinach Apricot-Grated Cheese Salad Pineapple Sherbet • Cream of Pea Soup Chow Mein With Fried Noodles Buttered Wax Beans Green Salad, French Dressing Apple Betty, Whipped Cream	**17** Grapefruit Half Poached Egg, Cinn. Toast • Vegetable Soup Fried Scallops, Tartare Sauce Parsley Buttered Potato Green Peas Carrot-Raisin Salad Coconut Cream Pie • Clam Chowder Salmon Patties, Parsley Cream Sauce Buttered Asparagus Stuffed Celery Frozen Peaches	**18** Tomato Juice Soft Cooked Egg, Toast • English Beef Broth Meat Loaf, Spanish Sauce Mashed Potatoes Buttered Whole Carrots Coleslaw Gingerbread, Whipped Cream • Chicken Noodle Soup Ham à la King on Cornbread Pineapple Cottage Cheese Salad Vanilla Cream Pudding
19 Grapefruit Juice Bacon, Coffee Cake • Blended Juices Fried Chicken, Cranberry Jelly Mashed Potatoes French Green Beans Lime Gelatin Fruit Salad Butterscotch Sundae • Chicken Broth Potato Salad, Sliced Ham Dill Pickles, Stuffed Olives Peach Half Salad Pan Rolls Sponge Cake, Lemon Icing	**20** Orange Juice Poached Egg, Toast • Consommé Ham Loaf, Cream Sauce Parsley Potato Buttered Lima Beans Pineapple Cottage Cheese Salad Date Torte, Whipped Cream • Vegetable Soup Bacon, Lettuce and Tomato Sandwich Green Salad, 1000 Island Dressing Fruit Cup, Cookies	**21** Stewed Prunes Soft Cooked Egg, Roll • Chicken Rice Broth Roast Veal, Dressing Escalloped Potatoes Glazed Parsnips Molded Cider Salad, Mayonnaise Chocolate Pie • Split Pea Soup Meat Patty With Onion Gravy French Fried Potatoes Carrot Curls, Celery Hearts Frozen Raspberry Tapioca	**22** Grapefruit Half French Toast, Sirup • Egg Drop Soup Liver and Bacon Baked Potato Creamed Green Beans Sliced Cucumber Salad Cherry Crunch, Whipped Cream • Cream of Spinach Soup Chicken Pot Pie, Biscuit Pear Half With Fruit Cocktail Salad Caramel Cake	**23** Chilled Applesauce Scrambled Eggs, Bacon • Beef Broth Breaded Pork Chop Duchess Potato Seven Minute Cabbage Spiced Peach Salad Orange Sherbet • Chicken Noodle Soup Cubed Steak, Mushroom Sauce Baked Potato Head Lettuce, French Dressing Canned Plums	**24** Blended Juice Blueberry Muffin, Jelly • Celery Broth Fried Shrimp, Tartare Sauce Mashed Potatoes Stewed Tomatoes Coleslaw Pumpkin Pie, Whipped Cream • Cream of Potato Soup Egg Salad Sandwich on Whole Wheat Shoestring Potatoes Banana-Orange Salad Pear Brownie Pudding
25 Tomato Juice Fried Egg, Toast, Jelly • Cream of Vegetable Soup Beef Pot Roast With Gravy Mashed Potatoes Whole Carrots Grapefruit-Apple Salad Shaum Torte • Beef Barley Soup Acorn Squash, Pork Patties Danish Spinach Tossed Salad With Sour Cream Dressing Filled Cookies	**26** Apricot Nectar Bacon, Sweet Roll, Butter • Pineapple Juice Baked Ham With Raisin Sauce Mashed Potatoes Cauliflower With Buttered Crumbs Molded Cranberry Salad Peppermint Ice Cream • Cream of Mushroom Soup Cold Roast Beef-Swiss Cheese Potato Chips, Pickles Sliced Tomato Salad Coconut Layer Cake	**27** Stewed Mixed Fruit Poached Egg, Toast • English Beef Broth Spanish Steak Fluffy Rice Green Beans Golden Glow Salad Baked Apple • Lentil Soup Chicken à la King on Hot Biscuit Blushing Pear Salad Apricot Upsidedown Cake	**28** Orange Juice Soft Cooked Egg, Toast • Chicken Noodle Broth Pork Chop, Hunter Style Mashed Potatoes, Gravy Diced Rutabagas Date Waldorf Salad Lemon Chiffon Pie • Vegetable Soup Roast Lamb, Mint Jelly Oven Brown Potato Green Peas Chef's Salad With French Dressing Canned Sliced Peaches	**29** Grapefruit Halves French Toast, Sirup • Corn Chowder Hungarian Goulash Casserole Dumplings Head Lettuce, Roquefort Dressing Chocolate Ice Cream • Cream of Tomato Soup Tuna Salad on Bun Brussels Sprouts Carrot Strips, Olives Fruit Cocktail, Fig Bars	

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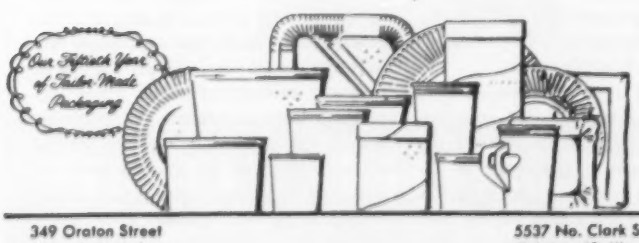

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Ask yourselves these seven questions

Before Buying Resilient Flooring

JOHN F. RHILINGER

OF THE many different types of resilient flooring materials offered on the market today, I should like to compare the six types most generally accepted for institutional use: asphalt, vinyl-asbestos, rubber, cork, vinyl, and heavyweight linoleum.

With flooring, as with everything else that we buy, our aim is to realize the *greatest ultimate value* for every dollar spent. When we buy resilient flooring, we usually are spending several thousands of dollars, an expenditure that demands a great amount of thoughtful consideration.

The task of selecting the best material for a specific purpose seems to be a difficult one. However, if we understand a little about the properties of each, our difficulty is minimized by the simple process of elimination. The greatest task, in the end, undoubtedly will be the selection of color or pattern. This probably is best left to those in charge of decoration or to those who will "live with" the floor. In some instances, the design or color may affect the price, but the difference usually is negligible.

Before we can make an intelligent recommendation as to which type of material to buy, we must know the answers to the following questions:

What is the location of the floor? If the floor is on or below grade, several types are automatically eliminated since they are not recommended for this type of application.

What is the type and condition of the subfloor? Some of the materials are adversely affected by alkaline deposits in cement. Dampness in the subfloor also will limit our selection. Badly worn subfloors will require considerable costly preparation, depending upon the resiliency of the material.

What are the amount, type and concentration of traffic expected? For heavy traffic areas, the tougher asphalt and vinyl content tiles will give longest wear. For lighter traffic areas, not exposed to weather conditions, our selection might be rubber flooring.

What types of materials are most likely to be spilled or tracked onto the floor? Heavy objects dropped onto the more brittle floorings, like asphalt, will crack or otherwise damage the tile. Greases, oils and acids will damage most types. Although pure vinyl might afford the best protection against acids, greases and alkalis, manufacturers caution against its use in areas subject to frequent spillage of acids. For a laboratory floor, therefore, it probably would be best to select one of the several types of cement composition floorings in lieu of a resilient flooring.

Are noise and underfoot comfort important factors? Cork and rubber

---

From a paper presented at the New England Group meeting of the National Association of Educational Buyers.

Mr. Rhilinger is purchasing agent of Dartmouth College.

Let's not clean away dollars and man-hours with costly, inadequate floor care

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would be the first consideration here, provided it could meet the other specifications. Cork is selected mainly because of its acoustical properties.

How frequently can we refinish the floor? All of these materials require occasional refinishing to ensure maximum life and pleasing appearance—some more frequently than others. In instances where it is not possible to refinish the floor more than once or twice a year, asphalt or vinyl-asbestos finished with two coats of asphalt finish instead of wax will wear longer than some of the other tiles insufficiently waxed. I doubt that the additional cost of pure vinyl tile is justified on this basis alone.

Is initial cost the most important factor? This important question arises here as it does with every transaction. We are considering *ultimate value* not always realized from *lowest initial cost*. Occasionally, it might be advisable to request a budget increase rather than to spend available funds for an installation that will not meet actual requirements. It might be wise to consider the possible use of underlayments, several types of which are available in sheet form and are used between badly worn or loose subflooring and the resilient tile. The function of underlayments is to supply a firm base for the tile. In figuring the cost of the underlayment, we should take into consideration the fact that the labor of sanding is eliminated, some of the nailing is unnecessary, and it is not necessary to apply felt under the tile. The total *additional cost* for the installation would be approximately one-half the total price of the underlayment material. This additional money, spent in the beginning, might ensure maximum life from the flooring.

PROPERTIES OF EACH TYPE

Let us consider briefly the properties of each type.

Asphalt: Composed mainly of asphalt binders and asbestos fibers, asphalt tile is cheapest of all. It resists normal moisture and, therefore, is suitable for use on all types of floors—on grade, below grade, or suspended. It is relatively easy to clean, nearly fireproof, resists cigaret burns and ink stains, and is very durable. However, because it is hard and brittle, it chips easily, tends to crack under heavy loads, is least quiet of all, and requires a very even subfloor to prevent cracking under normal traffic conditions.

Being soluble in grease, oil, gasoline and other solvents, regular standard asphalt tile will not wear well in areas where it is exposed to these substances. It is obvious, also, that asphalt tile should not be cleaned or waxed with materials containing any of these solvents. During the past few years, manufacturers have offered special greaseproof asphalt tiles that overcome this problem, at least to some degree. Nevertheless, I have not been convinced that it is the best answer to the grease problem.

Vinyl-Asbestos: This material is similar, in most respects, to asphalt tile. The combination of asbestos fibers with vinyl plasticizers makes a more flexible tile. It, therefore, will conform more readily to uneven surfaces without cracking. The addition of vinyl also makes it more durable and gives some resistance to oils, greases, alkalis and solvents. The cost is approximately double that of asphalt tile.

Rubber: Since World War II, synthetics have proved much more satisfactory for flooring purposes. Rubber tile is used chiefly because of its sound absorbing qualities and its attractive

appearance. Very resilient, it has high resistance to indentation and abrasion. It will not crack easily. However, it is adversely affected by excessive heat, moisture and the solvents referred to. It is suitable for grade level installation, provided a waterproof cement is used, but should not be used below grade or in areas subject to excessive dampness. The cost of rubber tile is approximately two and one-half times that of asphalt.

Cork: Ground cork and resinous binders make up this attractive tile. Today it is used mainly for its acoustical properties and underfoot comfort. Because it stains easily and is difficult to clean, it is not suitable for most institutional applications. The cost of cork flooring is high in comparison to the cost of other flooring.

Linoleum: Heavy gauge linoleum is composed of oxidized linseed oil, finely ground cork and wood flour, fillers, color pigments, and resinous binders. It is relatively easy to clean and offers special effects in design. It cannot be used on grade, is subject to indentation from heavy objects, and has shorter life than any of the others.

Vinyl: This most recent addition to the resilient flooring family is most versatile of all. Composed of vinyl-chloride resins and plasticizers, its main advantage is resistance to grease, oils, fats, mild acids, alkalis and detergents. Extremely resilient, it recovers from indentation rapidly. Color is constant throughout the thickness of the tile. It is easy to clean and may be waxed with the longer wearing solvent type of waxes. Vinyl is highly resistant to abrasion. The main disadvantage of vinyl is the cost, which runs approximately five times that of asphalt.

Variations in weather conditions may play a part in our selection. It does not necessarily hold true that a flooring used in warm, dry climates will be satisfactory in areas of seasonal hot and cold, or that a material giving excellent wear under soft soled street shoes will wear well under heavy boots or similar footwear.

PROFIT BY OTHERS' EXPERIENCES

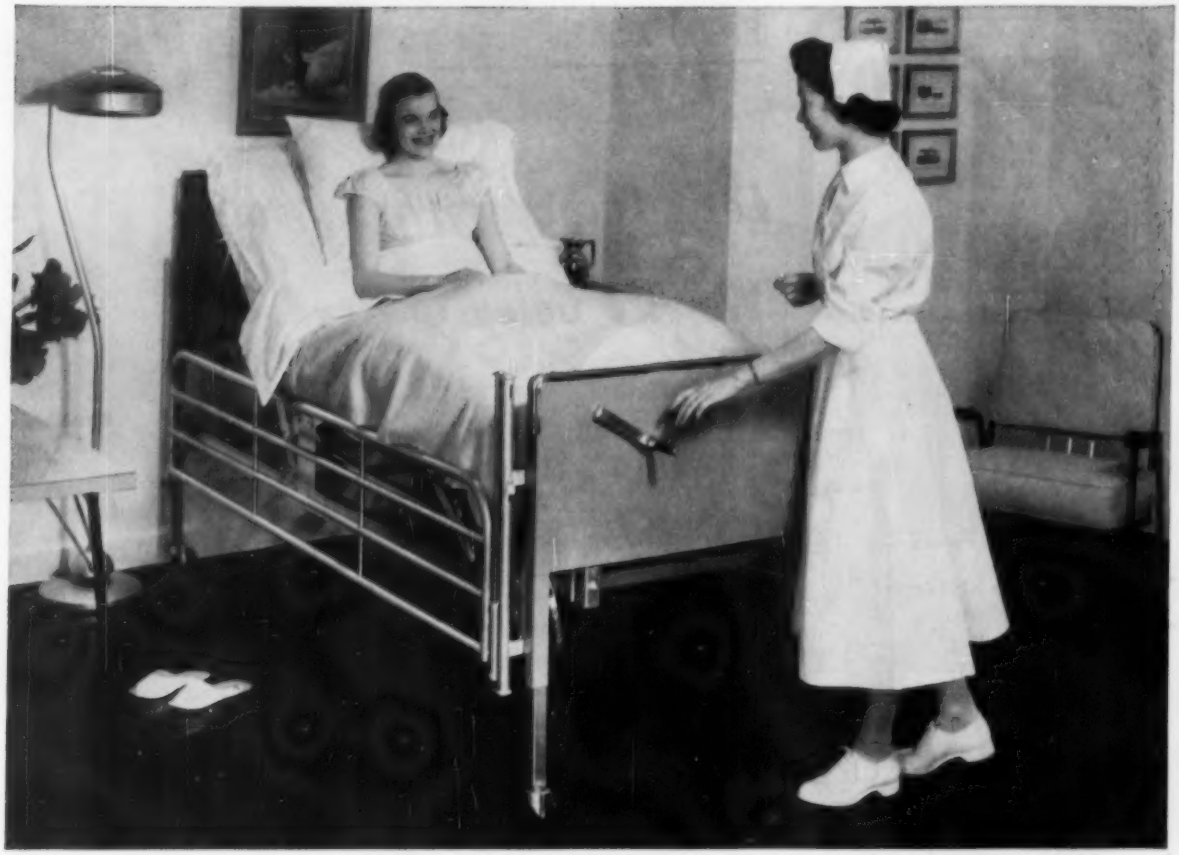
You can profit by the experiences of others. Investigate in your own immediate vicinity and see what results are being realized from different types of flooring for a given application. Consult several flooring contractors and study the recommendations of each before making a decision.

The person who buys the resilient flooring should know something about its upkeep. In general, most of these materials react unfavorably to excessive amounts of water. Indeed, many cases of floor deterioration can be traced to the improper use of water and detergents.

There is some difference of opinion on the matter of waxing vinyl tile. Originally, the manufacturers emphasized the fact that no wax was needed to maintain the original high gloss, but it is now generally accepted by the manufacturers that wax can be used to advantage with vinyl as with the other types.

PROPER CARE NEEDED

Regardless of the type of flooring, frequent "dry" maintenance, with occasional waxing, is required if you expect to get the most out of your investment. Care in the selection of materials to be used for cleaning and waxing will pay dividends, for, regardless of the material selected and the price paid, unless you give it the proper care you may quickly begin to subtract from, rather than add to, the appearance of the physical plant.



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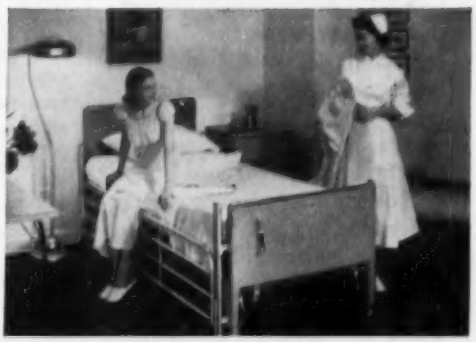

Dependable new construction H-45 safety sides on the Vari-Hite assure patient's safety. Lowered posts make sides inconspicuous. In lowered position there's plenty of room underneath H-45 sides for overbed tables and foot room.

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HOUSEKEEPING

Let's Encourage Assistants— We Are Going to Need Them

THE shortage of qualified applicants for housekeeping positions not only on the executive but, more especially, on the assistant and supervisory levels is alarming many thoughtful executive housekeepers, as well as hospital administrators. In any growing profession, there should be a sizable group of assistants in training for executive jobs. There is no such group in the field of institutional housekeeping, and the lack of it has inspired this inquiry by an executive housekeeper and the administrator of her hospital* into the underlying causes of the shortage.—ED.

*Names withheld on request.

THE letter on page 132 was written by the administrator of a middlewestern institution to his executive housekeeper after strenuous efforts to obtain qualified key people for the housekeeping department had proved futile.

At the time this letter was written it seemed advisable to employ an experienced housekeeper in order to save time. After considerable search, an executive housekeeper was located who was interested but she refused the position because she would have lost status in the National Executive Housekeepers Association by accepting it. According to the by-laws of this organization only one assistant housekeeper in any given institution can be a member of the N.E.H.A. In this particular hospital one had already been accepted as a member so the new assistant would not have qualified.

Because the administrator was at a complete loss to understand such policies, and certainly not in sympathy with them, he presented this letter.

The by-law governing admission of assistants to association membership militates against recruitment in still another way, that is, the fact that assistants are admitted only as associate members and have no power to vote.

The American Hospital Association through its committee on hospital housekeeping is trying to alleviate the shortage of housekeeping assistants. It already has written one book on housekeeping and is currently writing a sequel which will aid housekeeping instructors in teaching. The hospital housekeeping course given by the A.H.A. at Michigan State is open only to housekeepers recommended by administrators. However, the A.H.A. institutes on housekeeping are open not only to housekeepers but to any hospital employe upon the recommendation of administrators.

The A.H.A., in cooperation with committee members, held several round table discussions on housekeeping at its annual convention in Atlantic City this year. The discussions were open to housekeepers and other interested persons.

Two years ago the committee rec-

(*Continued on Page* 134)

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NAME AND TITLE

ADMINISTRATOR STATES THE CASE FOR BETTER LEADERSHIP

MEMORANDUM
EXECUTIVE HOUSEKEEPER:

"Since we are having so much trouble finding adequately trained supervisors for your department, I wish to inquire of you what the National Executive Housekeepers Association and also the American Hospital Association's housekeeping committee are doing to help solve this problem.

"It would seem to me that both of these organizations should take the responsibility for seeing to it that an adequate supply of well trained key personnel is available in the housekeeping field so that supervisors are available who can be advanced to the positions of assistant executive housekeeper and executive housekeeper, when the need arises.

"Certainly the National Executive Housekeepers Association should be vitally concerned with this problem. If it is not doing something to meet the situation, other than promulgating short courses at Michigan State, Cornell University, and a few other colleges, it seems to me it is not doing the job which one would expect of an association worthy of the name.

"Another phase of the problem that concerns me is that we have seen situations arise where an executive housekeeper wanted to take a position as assistant in a large hospital but would lose status in the N.E.H.A. if she left a 100 bed hospital, let us say, where she held the title of executive housekeeper to take a job as assistant, even though the responsibility in the larger institution might be infinitely greater. This is hard to comprehend and seems a bar to progress in the hospital field.

"If these organizations [N.E.H.A. and A.H.A.] are not going to train personnel, obviously someone else has to do it, but the question is, who? I would appreciate any efforts that you can make in the direction of suggesting to the American Hospital Association or the National Executive Housekeepers Association that they assume leadership so that a crisis is not always upon us when certain key people leave.

"If the housekeeping profession is a profession—and I certainly believe it is at this point because of its complexities—then the national organization should state a progression of training and initiate this, if possible.

"On-the-job training for housekeeping is only partially successful and, indeed, prior training is necessary because these positions are now so complex. Nevertheless, owing to the scarcity of personnel, hospitals and, apparently, the hotel field, also, have been very lax in allowing people to enter housekeeping positions by accident.

"Thank you for your attention to these ideas. I certainly hope that something can be done by the organizations concerned before others, who should not be as vitally concerned, have to 'take the bull by the horns.'"

—ADMINISTRATOR

ASSISTANTS—

(*Continued From Page* 130)

ommended that recognized hospitals and executive housekeepers accept trainees. In order to do this, the support of well qualified assistants and supervisors would be required. This movement has not been too successful, which is not surprising in view of the N.E.H.A.'s refusal to accept all assistants and supervisors into full membership.

This kind of exclusive membership policy is not conducive to advancement. Surely the N.E.H.A. must realize that there are many institutions that support more than one assistant, whose status in many cases is comparable to that of an executive housekeeper. Without these assistants, the hospital housekeeping departments could not be as efficient as they are. Also, the N.E.H.A. must know that many of these assistants are satisfied to stay where they are because they are aware that their particular jobs afford more experience and better salaries than they could obtain in many so-called "executive" positions.

Some N.E.H.A. chapters have started educational committees to report on articles, literature and research along their line of work. It is questionable whether these committee members really have time to devote to a study of the kind of material that executive housekeepers would not know about or could not obtain for themselves.

These educational efforts might be more effective if the chapters would consider themselves committees of the whole on education, and, at their meetings, relay their findings and research to all of the assistants and supervisors in the locality. Also it might be valuable to invite people who are not in the field but who seem to be good prospects to such informative gatherings. The executives have much to offer, but they cannot solve their personnel problems by sharing their skills only with one another. A plan should be developed whereby they could communicate their knowledge to understudies and thus produce more leaders for the field.

In order for administrative housekeeping to become a profession and also to overcome the existing personnel crisis in this field, more attention will have to be given to assistants, supervisors and recruits. They need the association and surely the association should feel that it needs them.

This problem is not new; it has existed for years and action should have been taken long ago. It is the opinion of many executive housekeepers that the term of office for national board members should be shortened and that they should not be reelected so that there can be more flexibility and stimulation of interest in the organization. Also, many hesitate to give their time and money to support delegates to the N.E.H.A. congress this year who might once again, through ignorance or lack of interest, fail to meet the serious personnel problem with constructive answers.

Since hospital administrators and hotel managers place great value upon housekeeping departments, executive housekeepers must assume responsibility for providing good and efficient successors, as well as a surplus supply of key people.

Will help come from the N.E.H.A. congress? Will these inadequate bylaws be revised to conform with modern standards? Will the organization advance or will it fall by the wayside? The answers rest with the executive housekeepers of the country.

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A.M.A. Protects GP's

(Continued From Page 52)

permitted to do a circumcision on a baby he delivered himself to the case of a man who reportedly refrained from operating on a patient for fear of what the tissue committee might find.

"When the tissue committee determines what I can do for my patients, I'm all through with the practice of medicine," he said.

Many speakers said the restrictions they described had been imposed in accordance with requirements of the Joint Commission on Accreditation of Hospitals, yet most of the restrictions reported went beyond requirements of the commission. Unfortunately, no representative of the Joint Commission appeared before the committee to make the commission's policies clear, as had been done at previous A.M.A. meetings, where Dr. Kenneth B. Babcock, commission director, set the record straight on the commission's requirements. It remained for a past president of the Academy of General Practice, Dr. U. R. Bryner of Utah, to read a statement explaining the commission's policy that staff membership and privileges should be extended on the basis of individual training and competence.

Another Academy president, Dr. John R. Fowler of Massachusetts, pointed out that requirements and instructions of the Joint Commission are plainly being used by individual hospitals and staffs to "mean whatever the local group wants them to mean."

Changing the Ethics. In another reference committee meeting, it was an outsider who provided the information that clarified a discussion about the proposed changes in the Principles of Medical Ethics. At hearings conducted by the Reference Committee on Miscellaneous Business, speaker after speaker stood up to warn against rewriting the principles which had "remained unchanged for so many years."

After several speakers referred in awed tones to the "undying, unchanging principles," a science writer in the audience pointed out that the Principles of Medical Ethics of the American Medical Association were first written in 1847, completely rewritten in 1902, rewritten again in 1912, again in 1940, revised in 1949, and revised again in 1954.

"That ended the discussion of undying principles," he reported.

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THE WORD FOR THE WIVES IS DISCRETION

(*Continued From Page 57*)

who reported on something she had done that she would always be glad she had done. Here is the way she tells it:

"My husband was politely fired one Monday from a former job, and I had promised to manage a snack bar for a large sale on Friday and Saturday of the same week. I went ahead with my job and worked hard though I did get the board chairman's wife to take over on Saturday. The women were grateful that I hadn't let them down so late in their plans and very appreciative to me. I was glad to leave them with a 'good taste in their mouths.' Luckily I did, for by the time I sold the house and could follow my husband to his new job, I'd been there seven more months. . . . I was left with a family to care for and no car. People were wonderful to me. I haven't forgotten and have tried to make it up to them as I can. We look forward to visiting there next year and should be well received."

What do the husbands think of a course of training for their wives? Only one wife reported that her husband "had no opinion." The other husbands have the very decided opinion that, as one put it, "It's the greatest."

The answer that best summarizes the views of both husbands and wives was this one:

"My husband feels that we were given an adequate background to what he was entering into and what our rôle would be in this new venture. He and I both feel that the wives having had a chance to meet one another and for all of us to get acquainted with the husbands and wives draws us closer together as a group even years after we are out of school. . . . We have a common bond and the husbands feel their wives are an asset to them because of the background they received at school. We can talk intelligently about our husbands' work with those in the field and their wives."

As has been pointed out, the course for wives has developed a definite pattern in the years since its inception, but it is not intended by the sponsors that it should remain static. They want new ideas and suggestions for improving it for the greatest benefit of the wives. Most of the respondents believe that the course is excellent as it now stands, but some of them offered such suggestions as these:

"Spend as much time as possible in group discussions about actual situations that confront wives of hospital administrators. Have several experienced women lead these groups."

"Enlarge on the position of an administrator's wife in regard to hospital activities, especially auxiliaries. I found myself in a peculiar position when asked repeatedly to participate and take a prominent rôle."

"More chances to talk with wives of hospital administrators would help a lot. A chance to meet administrators and their wives from small hospitals would be good. We didn't all end up in large cities."

"I can't think of any suggestions for improvement other than perhaps having meetings twice a month instead of once a month."

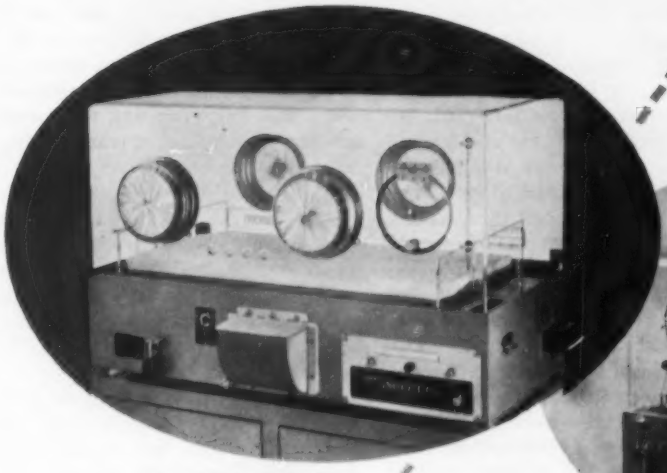
"One lecture, at least, outlining the general plan of the hospital with explanations of just how the money is acquired to run a hospital: the drives, donations and so on. And a very good definition of a nonprofit hospital that can be used when one is confronted with: 'What do you mean, nonprofit, when they charge what they do for rooms?' I have often longed for some concise answer that might help to explain the 'why' and yet not get into an involved discussion."

"Those of us who find ourselves in city or county situations could stand a little briefing on local politics—how to handle or avoid them. Politicians and their wives seem to be a 'special breed of cat.'"

Aside from these changes, all of the respondents obviously agree with the alumna who wrote:

"The education, of course, is not complete. Our process of learning must be mellowed by experience. But our year of theory has done wonders in shaping the trend our experience will take. We do believe that we are now more valuable to our husbands and hope to improve our worth as the years go by."

What counts is performance not resemblance



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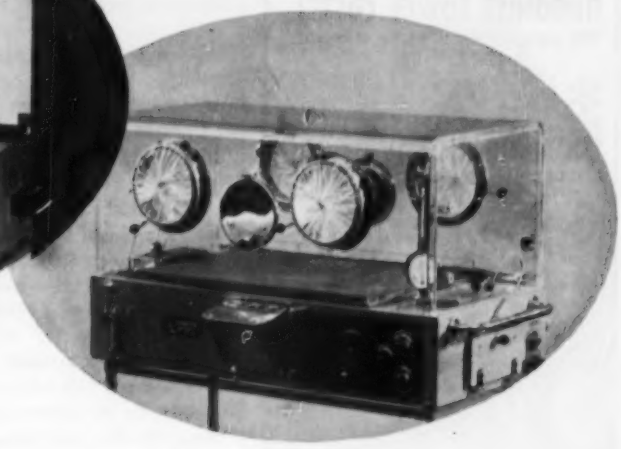

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Classify Accounts to Boost Collections

(*Continued From Page 64*)

posed system of credit and collection is the monthly review of accounts. Because the accounts are divided into files according to the source of payment, any segment of accounts receivable may be isolated and checked.

The method of control, then, is simply to pull out one file of accounts at specific intervals and check them for the date of discharge, date of payment, and source of payment. A schedule for checking is set up as follows:

Insurance (Blue Cross and commercial) can be checked during the first two weeks of any month. One week could be spent checking the "D" file (individual pay). Because this file contains the credit problems, a separate control is set up within this file as discussed in the previous section. This separate control is checked weekly. However, once a month the whole individual pay file should be checked and credit problems should be taken from the files and followed up.

Sometime during the last week of each month, the remaining files can be checked and the consequent follow-up to these accounts may be made.

THREE POINTS OF CONTROL

Within this system of credit and collection, there are three natural points of control.

The first point exists within the 24 hours following admission. After the admitting officer has gathered the admitting information and the credit clerk has completed the follow-up form per the instructions on her cards, the follow-up form is returned to the credit manager for review. At this point, less than 24 hours after admission, the credit manager has the information to determine if the patient is a credit problem.

The next point of control exists during the in-house billing procedure. Here the credit manager not only has the information on the follow-up form but also has the amount of the bill. This is the point at which the potential medically indigent patient may be checked. During the in-house billing, the credit manager has the opportunity to observe the progress of every account as it relates to the patient's financial situation.

The third natural point of control is the actual distribution of the patient's account. At this point the total bill is at hand and can be related to the patient's financial position and source of payment. Here the credit manager can check and follow up any real credit problem that has not appeared earlier in the system.

These three natural points of control can at any time be observed by the administration of the hospital. The administration would do well to check at these points from time to time to determine any failings of the system.

SHOWS CASH POSITION

One method of control is the daily business office report indicating the current receivables and current liabilities, and consequently showing the current cash position of the hospital. A sample of this business office report is shown in the table on page 63.

In terms of controlling accounts receivable, it is significant to note how the total accounts receivable are broken down into the subcontrol accounts. After this daily report has been reviewed for a period of time, the subaccounts establish a certain pattern that is in proportion to the total accounts receivable. These proportions remain relatively stable and soon the administration of the hospital can tell at a glance if any file is getting significantly larger as a result of some failing of the system.

Another means of control is the monthly aging of accounts, horizontally and vertically.

The horizontal type of aging enables the administration to select the total receivables for any month and follow those receivables month by month to check the progress of collections. The vertical aging of accounts receivable presents another method of control that is made available by this system of credit.

It is not the purpose of this article to offer the complete answer to hospital credit and collections. It does, however, present one system of credit and collections that has worked in one community. Perhaps this system is flexible enough to be of value, either in whole or in part, to other hospitals.

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Somebody Has to Pay for Patient Care

(*Continued From Page 84*)

patients. A special portion of the patient load is composed of clients of local or state welfare or possibly even federal welfare agencies. About how many of your patient days are from the local city or the state welfare agencies?

MR. R. JONES: In our case, about 8 per cent of our patient load are either county or city welfare cases.

DR. ROREM: In your hospital I estimate that would be about $80,000 a year, which is the equivalent of the income on about two million dollars in endowment at 4 per cent. Now, sometimes we speak of a hospital having no endowment, and therefore having to finance itself from patients' fees. It seems to me that your community has created for itself a two million dollar endowment which is available to the institution.

MR. R. JONES: The over-all income has to support the hospital, and that comes from third-party payers, private patients, welfare payments—all these various groups. If we did not have the arrangement which we have now worked out with the county and city welfare agencies, providing that they pay us enough to cover our costs, we couldn't possibly manage, because we certainly could not pass all that load onto the private patients and expect them to pay it.

BURDEN IS ON PAY PATIENTS

MR. E. JONES: In many parts of the country that's just what they're doing. They are passing the load on to the private and semiprivate patients. Too few trustees and too few administrators recognize that in financing a hospital we're better off fighting the battle for cost payments for indigent patients and compensation insurance patients than we are trying to balance the budget by saving on the wrapping paper. They're putting too much emphasis on controlling and economizing a relatively small part of the hospital problem, to the detriment of proper emphasis on the income.

MR. ZIMMERMAN: One of my pet peeves is the concept in the community that a hospital has free beds. These are the two wickedest words in hospital administration today, because not only does the public misunderstand this concept but our own trustees misunderstand it! We talk about having free beds in hospitals and then, of course, no one wants to reimburse us at cost, because they expect us to give everything away! I hammer and hammer at this concept with my women's auxiliary and board of trustees: Every bed and every patient must be paid for by someone; there is no such thing as a free bed!

NEED TO GET ALL FACTS

MR. E. JONES: How much of the problem of getting facts that help the administration is due to failure of the chief accountant and the administrator sitting down and jointly trying to find out what information is needed to help control this institution?

MR. HUMBERT: I think that's the greatest problem.

MR. E. JONES: And isn't it true that if our accountants actually knew more about the administrative details of every department they'd be in a better position to produce figures which would help the administrator keep his finger on things?

MR. HUMBERT: I don't see how a man can be a competent accountant and not know the details of every department, if he studies his figures.

MR. E. JONES: This is what happens in industry. These technics of industry can be most useful in the hospital if they are bent and tailored and fixed to apply to the peculiarities of hospitals and the peculiarities of individuals that run the hospitals.

MR. HUMBERT: They are bent and fixed by industry to meet their individual problems; why shouldn't they be bent in the hospital field?

Because of their social characteristics, hospitals have been slow in adopting methods proven successful in industry. Business methods can be bent, as they have been bent by industry, to meet any given problem in hospital administration. For intelligent administration hospitals must adopt sound business practices. Every industry is different, and it is time hospitals stop using the expression "hospitals are different" to explain away laxity in administration.

Labor Calls the Shots on Health Service

(*Continued From Page* 87)
as an excuse for further increases in hospital charges, room rates, and medical and surgical fees, leaving the members confronted with the same extra charges, over and above their insurance benefits, that they had to pay before.

"Through this process, in some areas we have seen surgical benefit schedules in the plans negotiated by union groups rise steadily over a few short years from a maximum of $150 to maximums of $450 or $500, without actually improving the position of the membership in relation to their medical bills. In fact, in some cases, grounds exist for a very strong suspicion that individuals covered by such plans have been left no better off than they had been without it.

"To the extent that this tendency exists, these plans may properly be described as 'doctors' benefit' plans, rather than employed-benefit plans."

These statements are representative of those made by responsible labor officials when requested for their views on the shape of things to come. No union official failed to make similar comments.

Without commenting on the merits or demerits of the argument for "service benefits" for physician services, it certainly must be said that this is a problem that cannot be neglected in an evaluation of labor views. So intense are the desires for "service benefits" that it is reasonable to say existing tensions between organized medicine and organized labor will not be eased until the problem of "service" medical benefits is resolved to the mutual satisfaction of both parties.

Labor is not alone concerned with the problem of "service" benefits for physician services. In a projection of the shape of things to come, if only to set forth an unresolved problem of both purchasers of prepaid protection and providers of services, it should be said that many employers, at various meetings throughout the country, are as articulate on this issue as are labor leaders. In some instances, employers and unions are seeking the same solution and in other instances, of course, the employer would resolve the problem differently than would the union.

If we view the problem of "service" benefits objectively, if this is possible, and take into account both union and employer attitudes, it would seem that the one thing which would assure the future success of the voluntary prepayment idea, as a substitute for government action, would be a satisfactory resolution of this issue. Unions and employers, where "service" benefits have been developed for the middle-income groups, seem to feel that a reasonable answer has been found. On the basis of this observation, "service benefits" for families with incomes under, say, $6000, would do more to further the cause of voluntary prepayment than any one measure which could be instituted. Some, however, would place the income ceiling at a higher level.

BROADEN BENEFITS

Aside from the problem of "service benefits" for physicians' services, the second major consideration, as expressed by labor leaders, is the whole problem of broadening the benefit base. Every labor leader who discussed his views stressed the need for less emphasis on in-hospital surgical benefits and more emphasis on the full range of medical services which will detect disease early in the course of an illness and provide for prompt and expert diagnosis and for early treatment. To the extent that labor views are an indication of the shape of things to come, the prepayment agency of tomorrow will place far more emphasis on prevention, diagnosis and early treatment than on, even, major illness costs. The pressures are accumulating throughout labor for types of coverage which will not only give protection against the economic costs of illness but which will also give protection against illnesses which can be minimized by early detection and diagnosis.

Labor pressures for the closed panel approach to prepaid protection, and for union-operated clinics, stem almost entirely from the desire for comprehensive protection—that is, protection which will provide assurances of early disease detection and diagnostic procedures on one hand, and on the other hand, protection against economic barriers to medical care. This problem, of course, cannot be met by simply writing into labor-management contracts that such and such types of protection shall be made available by the employer. It is, rather, a matter which the providers of services and the prepayment agency must together work out because it is both a problem of benefits and of organization of services. It is not an easy problem to resolve. But, in the shape of things to come, it will be worked out because the existing demand for a solution is firmly rooted.

A benefit area of major annoyance, and one that is on the agenda for correction, is the existing gap between hospital service and medical service plans on items of service that in many communities fall between the two plans. Labor officials, without exception, are committed to the "service" benefit principle for hospital admissions as well as for physicians' services. When a labor leader tells his membership that a "service" benefit has been negotiated for hospital admissions he finds it difficult to explain why, for example, anesthesia is covered in one hospital and is not covered in another even though the two hospitals may be located across the street from each other. There is also the troublesome problem of radiology and pathology as well as physical therapy.

One large union said it was going to drop its present prepayment arrangements because of this problem. Another union had already changed carrier on this issue. Unions do not understand, nor are they particularly interested in, the issue of what *is* and what *is not* hospital service. Neither can they understand why different hospitals in the same community make different kinds of arrangements for physician services rendered to inpatients. But frustrations do arise when the union believes, and is told, they have "service" benefits for all hospital admissions only to find out that in some hospitals such services as anesthesiology and radiology are not covered, or, if they are covered, are on a cash indemnity basis.

When the cash indemnity approach is applied to these items of service rendered in-hospital patients who thought they had "service" benefits for hospital care their frustration is more intense than, for example, in the case of cash indemnity for the attending surgeon's services. Where "service" benefits do not exist for at-

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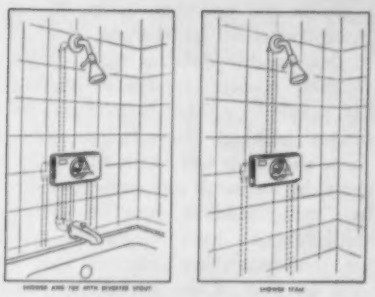

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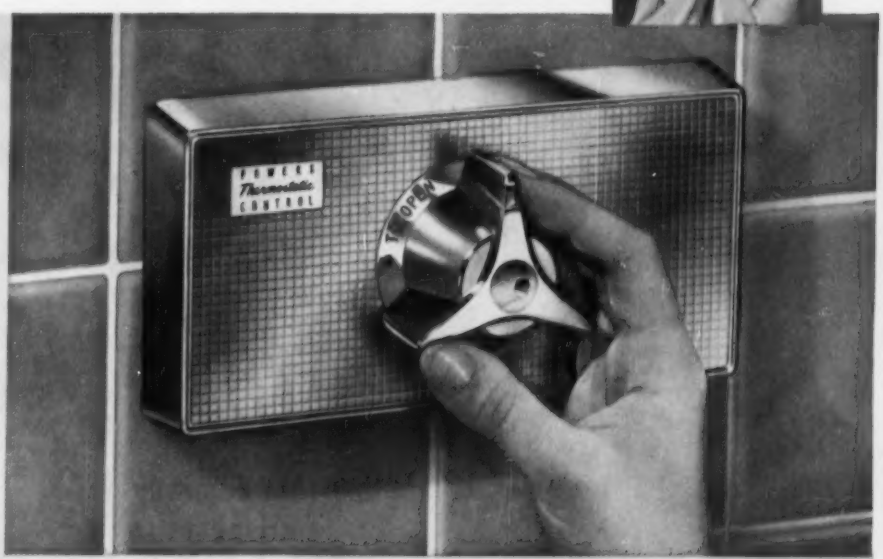

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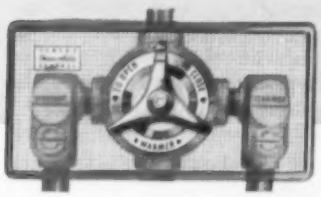

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tending physician services this fact is known. But when the patient who thinks he has "service" benefits for all care associated in his mind with hospital service, whether or not this concept is realistic in the particular situation, finds that certain items are not on a "service" basis a considerable amount of dissatisfaction results.

The lack of patient understanding on the issues involved helps to confuse him and further contributes to the dissatisfaction on this point that prevails among labor officials. In the shape of things to come there will need to be a solution to this problem which will permit the level of hospitalization protection to be the same regardless of the particular hospital selected by the patient or the arrangements made by the hospital with its staff physicians.

While at one end are preventive and diagnostic services, in the shape of things to come, at the other end are benefits for chronic and prolonged illness and for unusually expensive illnesses. Unions, with few exceptions, appear not to want coverage for incidental office calls and the very occasional home call but pressure for full protection on all other items of service is not likely to lessen. Although with no higher preference than for preventive and diagnostic service benefits, benefits for prolonged illness, whether at home, in the hospital or in a nursing or convalescent home, are on the list of items which employers will be asked to negotiate in the next few years.

In general, union support for the insurance industry's "major medical" type of benefit—that is, a lump sum cash indemnity allowance with a deductible and co-insurance feature—is conspicuous by its absence. This is understandable because the "major medical" benefit concept is contrary in principle to the basic tenets of union thinking. There is little likelihood that labor will in the future support the insurance industry's approach to "major medical" benefits. Those unions which have bought this type of protection have indicated that it was an interim step to full "service" benefits and that the gaps in protection would, over a period of time, be "negotiated out." Most unions will undoubtedly skip the "major medical" step toward comprehensive protection and negotiate directly for unlimited stays in short-term general hospitals for patients requiring acute care, supplementing this with nursing and convalescent home care benefits for patients with prolonged illness who do not need acute hospital care. Parallel benefits for professional care on a "service benefit" basis will undoubtedly be urged on employers simultaneously.

Benefit improvements, which are certain to be made in negotiations from year to year, will be accompanied by removal of most restrictions that prevail in present prepayment contracts. In the next 10 years virtually all benefit restrictions will probably be removed and the prepayment agency's contract with the subscriber will be no more complicated than an airline or hotel credit card. This will necessitate greater uniformity in benefits throughout a community and more than likely a reversal of the present trend toward "experience-rating" individual employe groups. Some employers have already joined the unions in the drive for community-wide benefits and community-wide rates as the soundest approach over the long term. This trend can be expected to continue if for no other reason than

that the use of electronic mechanisms throughout the prepayment administrative process will be a force for greater uniformity in benefits and in individual communities a force for greater centralization of prepayment administrative procedures. Unions feel it is not efficient to continue the present practice of 600 to 700 prepayment agencies selling thousands of varieties of benefit patterns in a single community.

An early expansion in prepayment population coverage will be the extension of protection to all dependent members of the employe's household including unemployed children, parents and others who make their home with the subscriber. The largest single group of uncovered persons today are those persons who live in the household of employes with protection. Just as labor pushed first for employe coverage and then for coverage of spouse and dependent children, labor will, in the future, push for household coverage. On the agenda, also, is coverage during periods of unemployment regardless of the reason for absence from work. This includes coverage during retirement whether for reasons of disability or age.

For unions with members in more than one community, or in more than one prepayment plan area, the shape of things to come indicates, for the survival of the voluntary prepayment idea, the establishment of uniform benefits for the entire employe group regardless of where the employe may live and work. In the past few years uniform benefits for all employes under a given collective bargaining agreement have become a major issue. There are many reasons this issue has come to the front but regardless of the reasons it is a practical impossibility for a union or an employer, under a national agreement, to provide fewer benefits and a lower level of protection for employes in one area than for employes in another area. This is a problem peculiar to the nonprofit community plans because the insurance company is not confronted with variations in benefits from community to community.

Most unions want the strengths inherent in local community administration of prepayment. They want the many advantages that the nonprofit plans, over a period of years, can offer but they also want, without jeopardy to local autonomy in administration, national uniform benefits and, in some instances, national uniform rates. The concept of national uniformity in benefits and rates is not incompatible with local autonomy in administration. Quite the contrary, local autonomy is lost if the community prepayment plans do not work out a satisfactory mechanism for provision of protection under labor-management contracts nationally negotiated and the union and employer are forced to select an insurance company operating nationwide. A satisfactory plan for coverage of federal employes, with uniform benefits and uniform rates throughout the country, will be a demonstration of the flexibility of the voluntary community prepayment plans in meeting problems peculiar to large employers with employes throughout the United States.

The danger of government intervention in the prepaid health care field is probably greater today than at any time in the past several decades. Some hundred million people are now participating in voluntary prepayment arrangements. Voluntary prepayment is to the health field what monthly collections are to the public

utilities and installment buying is to such industries as electrical appliances and automobiles. Regardless of which political party occupies the White House, or controls the Congress, it will become increasingly feasible, politically, to propose government measures to strengthen voluntary prepayment as well as to extend the advantages of voluntary prepayment to the uncovered population groups. Unions can be expected to encourage government action to supplement the floor of protection won in collective bargaining and to fill the gaps in the voluntary prepayment structure. There is no possibility, on the other hand, that unions will seek government action to accomplish what can be done more successfully, or as successfully, in collective bargaining.

As long as the prepayment plans work with the providers of services constantly to improve the levels of protection, meet the new needs that arise, and at the same time assure the public that every possible measure is being taken to keep costs as low as possible, the threat of government action to abolish the voluntary prepayment approach is past. But if voluntary prepayment should stagnate, become unresponsive to union, employer and public demands for constantly improved protection at the lowest possible cost, government intervention will occur. Today, the immediate threat is not government control of prepayment; rather, it is the danger that too much satisfaction will be found in how far we have come. Now is not the time for rear-view mirror gazing and pats on the back for a job well done.

In the shape of things to come there is a big job ahead, a job that will not be done unless there is a reasonable measure of dissatisfaction with accomplishments thus far. The job ahead requires a long view, a view that can see the forest and not just the trees. The key to tomorrow's success is teamwork, a pulling together, a give and take, to accomplish the larger goals of making the voluntary prepayment mechanism a permanent success. The tools for the task have been forged, the will to use them prevails to an extent never before known. There are, really, no insurmountable barriers in the road ahead if we are committed to realizing the full potential of the voluntary prepayment mechanism—and to this we are all committed.

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...brings you these TWO BASIC WAYS

to cut water softening costs

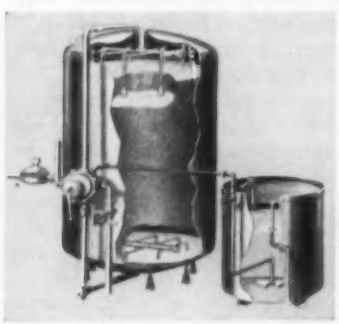
For nearly a half-century Elgin has had a way of coming up with major — yes, *revolutionary* — developments in water conditioning.

Here are two basic advancements — headed by the exclusive Elgin "Double-Check" principle — that can save dollars for you: . . .

1 ELGIN ALONE *can offer you the "Double-Check" Water Softener*

By preventing the loss of zeolite, the "Double-Check" manifold in today's Elgin Water Softener makes possible a far deeper bed of zeolite, far more efficient back-washing, far more effective salting. The remarkable over-all result is up to 44% *more* soft water per regeneration than can be supplied by other softeners of *equal size* using the *same* zeolite! All this with less salt and a profitable saving of time due to fewer regenerations.

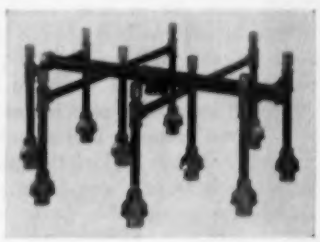
Elgin Water Softeners are also available with fully automatic operation — the Elgin "Ultramatic" — the most dependable automatic water softener ever produced.



The Elgin "Double-Check" Softener — available for manual, semi-automatic, and fully automatic operation.

2 ELGIN ALONE *can make your present water softener into a "Double-Check" softener*

Because the "Double-Check" system is comprised of basic, integral units, it can be applied to your present softener (*any make*) to give it the basic advantages of the current model Elgin "Double-Check" Softener... up to 44% more soft water than it ever gave before. The Elgin "Ultramatic" unit can also be applied to your present softener to make it automatic. And note this: it may be possible to give—



The patented Elgin "Double-Check" manifold system is readily and economically adapted to your existing softener.

New life to your old softener with Elgin High Capacity Zeolites

In hundreds of applications the newly developed ion exchange zeolites have stepped up soft water output 3 to 10 times. This, of course, means *beyond* the increase in capacity provided by the "Double-Check" manifold system.

Your Elgin Representative *will show you how you can get the maximum output of soft water at the minimum cost. Let us put him in touch with you. No cost or obligation whatsoever.*

ELGIN
Economical
WATER CONDITIONING
FOR EVERY NEED
SINCE 1908

ELGIN SOFTENER CORPORATION
144 No. Grove Avenue, Elgin, Illinois

It's Better to Build Out Than Up

(*Continued From Page* 71)

tively small nursing units. In large nursing units the architect tends to string out the inside services in a thin line to the full length of the nursing unit, using cross corridors to take up the space that would otherwise have no other use.

As in Beckley, so in Palo Alto and Tucson, we use the double corridor in the nursing units only for a length necessary to contain the service core in properly proportioned spaces. From there out we use the single corridor. Belleville being a small hospital, we find no need for the double corridor at all inasmuch as the nursing units with a single corridor are not excessive in length.

What about the Friesen system of supply which appears to imply verticality and short floor branches? We think that the Friesen contribution is valuable and can be used without sacrificing the principle of horizontal contiguity. Beckley is a clear example of that. It is embodied in the Belleville plans and it exists in the Palo Alto and the Pima County plans, or at least could be easily incorporated. It is obvious that if the Friesen idea were given predominant consideration we could not have much integration on a horizontal basis. Nevertheless, the idea of grouping supply services and placing them under one issue head can be accomplished to a considerable extent in a horizontal plan.

In the cases of Pima County and Palo Alto it is inescapable that processing and issuing should be done on more than one floor, and who can say that that is not justifiable in a hospital of 1000 beds? In the last two mentioned hospitals, therefore, the goods processed on the second floor (goods of a medical nature) would be distributed laterally on the second floor and sent down to the first floor to be distributed laterally there. For nonmedical goods originating on the first floor the process would be reversed. True enough, the horizontal runs from the distribution centers are long as compared with the Friesen ideal. But we feel there are many roads to creating the balanced hospital which serves the patient with efficiency, economy and in a gracious manner.

In proof of the unbelievable amounts of space which circulation and other repetitive items take up in a multistory building without our realizing it, let us consider not the elevators and their machinery, which comprise one of the most expensive items in any building, but just the elevator shafts as space which has to be created and paid for.

100 SQUARE FEET PER FLOOR

A single hospital elevator shaft represents about 100 square feet of space per floor. The Palo Alto and Pima County examples are planned to have a basement and three stories. Each elevator would therefore require 100 × 4 = 400 square feet of space, not counting pit and penthouse, and as there are to be four elevators the total space required would therefore be 400 × 4 = 1600 square feet.

The same hospitals with a base-plus-shaft solution would require a basement and two-story base, 14 nursing unit floors (each with a double nursing unit of about 70 beds), and one obstetrical delivery floor, making a total of 18 levels not counting pit and penthouse. Such a hospital building would have at least 10 elevators[9] and people, particularly the doctors, would most likely not be happy with the service. The space required would be 100 square feet × 10 × 18, or 18,000 square feet. At $22 per square foot, the elevator space in the horizontal solution would amount to (1600 × 22) $35,200, and in the vertical solution to (18,000 × 22) $396,000, representing a difference of $360,800. The difference in cost of the elevators and their machinery would be about $865,000, making a total difference of $1,226,000 (not counting lobbies). As we have said, this does not count the operating costs or the lack of satisfaction with the service. The hospital with adequate elevators has not yet been built, because such adequacy is considered too expensive.

When the Empire State Building was being planned in New York, it was found that the chimney, if one were built, would require such a fabulous amount of floor space which could otherwise be rented that the decision was made to buy utility steam instead of installing a heating plant.

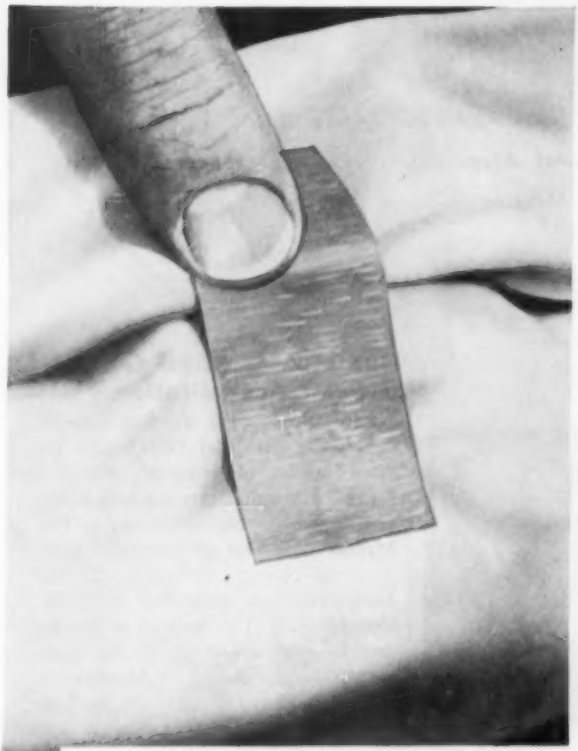
Our principal explanation of the small area per bed, which appears to be peculiarly characteristic of the horizontal or few-storied hospital, stems from the fact that the few-storied hospital is economical in circulation and otherwise repetitious spaces.

If we were to take the average four-storied *small* (under 100 beds) hospital plan, or the six and nine-storied larger hospital and lay their plans side by side, we would be shocked to realize the inordinate amount of space that is taken up by corridors, stairs, lobbies, elevators and other repetitious elements on each floor.

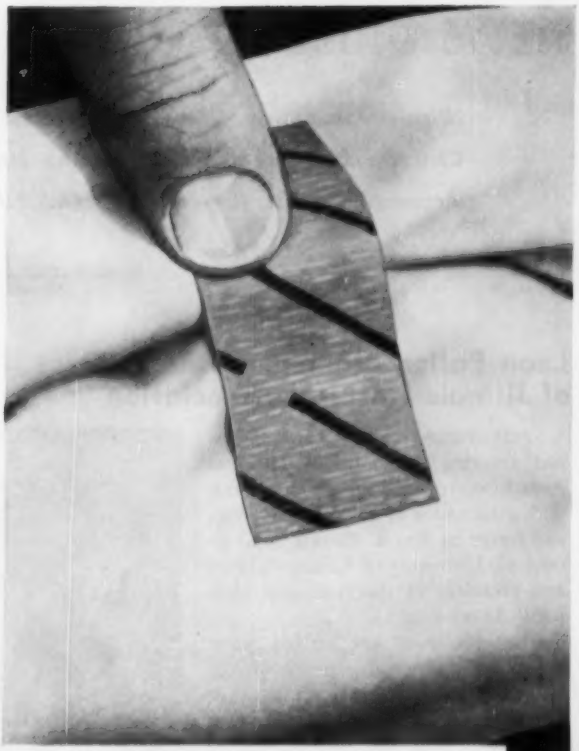
What about the distances? Anyone looking at the plan can see that great distances are involved in the large hospitals but appearances are deceiving. The nursing units used in our few-storied hospitals are no longer than other well planned nursing units in current practice. The distances involved in intercommunication between departments situated on the same floor are much shorter in time as well as in distances involved between departments located on different floors. The time of waiting for an elevator or the difficulties of maneuvering beds and stretchers in and out of elevators also has to be considered together with the cost of elevators, dumb-waiters and stairs. The long corridors in our plans are those which are not used frequently. It is the sum of the steps a person takes in a day in the performance of his most frequent duties that counts, not the length of the corridor which a person in a given function may have infrequent occasion to use.

How can one induce a plate of food to stay hot if it has to be taken to the patient over long corridors? The answer lies in the modern vacuum devices that are today widely used in hospital food service and, even here, time, effort and consequently personnel could be conserved by having tray carts, laundry and supplies moved about along the main corridors in electrically propelled trains.

[9]The Lima, Peru, hospital of 850 beds, Stone & Aydelott, associated architects, has 12 major hospital elevators.



BEFORE AUTOCLAVING. Here is what "SCOTCH" Brand Hospital Autoclave Tape looks like on bundles ready to be put in the autoclave.



AFTER AUTOCLAVING. These unmistakable markings tell you the pack has been through the autoclave. There is no possibility of error. The special inks used in this tape must be *intentionally activated,* and

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No danger that sunlight or radiator heat will bring out the distinctive stripes on this foolproof tape. When you see them on an autoclave pack (and they can be seen clear across a room) you're sure that pack has been through the autoclave. *This is not positive proof of sterility, of course—nothing on the outside of a bundle can prove that.*

Seals packs firmly in half the time required for pinning, tying, or tucking! "SCOTCH" Hospital Autoclave Tape No. 222 holds in high steam temperatures, leaves no stains or gummy residue, can be written on with pencil or ink.

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NEWS DIGEST

Illinois Association Elects Leon Pullen . . . Alabama Administrator Loses Civil Service Appeal . . . One-Man Hospital Accredited . . . Offer Hospital Accounting Course by Mail . . . A.S.T.A. Meeting Features Service Workshops

Leon Pullen Named President-Elect of Illinois Hospital Association

SPRINGFIELD, ILL. — The 33d annual meeting of the Illinois Hospital Association opened here last month with a discussion of hospital economics and forces by Ray E. Brown, superintendent, University of Chicago Clinics and president of the American Hospital Association.

The time has now arrived when decreased length of stay cannot any longer offset steadily rising costs of approximately 5 per cent per year, Mr. Brown said. Mr. Brown pointed out that hospital employes have gained salary increases of almost twice the average increase for the rest of the nation's workers. "Hospital employes were earning such low rates up to 1946 that it was necessary to increase their rates at a far more rapid rate than the rates of other workers in order to attract and hold desirable employes in hospitals," Mr. Brown reported.

The remainder of the first morning's meeting was devoted to problems of nursing service and nursing education. Dr. Karl Klicka, administrator of Presbyterian Hospital, Chicago, chairman of the session, said he is convinced that nursing education must follow higher standards. "What is going on now in nursing education is similar to what happened to medical schools 30 or 40 years ago," Dr. Klicka pointed out.

Mildred Lorentz, director of nursing at Michael Reese Hospital, Chicago, and past president of the Illinois League for Nursing, said that of approximately 800,000 graduate nurses in this country, only 390,000 are actually following and actively practicing their profession. She pointed out that nurses are not distributed evenly throughout the country in accordance with population needs and said that Illinois is a little better off than the national average, but that there is still a serious shortage of nurses in the state.

Wendell H. Carlson, left, 1955 president, Illinois Hospital Association, congratulates Leonard W. Hamblin at the concluding session of the meeting.

Anna Lucille Laird, director of nursing service, University of Illinois Research and Educational Hospitals, Chicago, pointed out that nursing education standards must be uprated rather than downrated. "The professional nurse is a team leader; because of this, the managerial aspect of her job must be included in the nursing curriculum," Miss Laird said. She urged the following conditions in hospitals:

1. Better personnel policies.
2. Better working conditions.
3. Active participation on the part of all professional nurses in devising methods to improve the care of patients.

Meeting concurrently with the Illinois Hospital Association was the state hospital auxiliary group. This group heard E. W. Jones, vice president of the Modern Hospital Publishing Company, point out that the only sound base for a good public relations program is the standards of the Joint Commission on Accreditation of Hospitals. He urged auxiliary delegates to familiarize themselves

(*Continued on Page* 176)

One-Man Hospital Gets Official Accreditation

CHICAGO. — For the first time in its history, the Joint Commission on Accreditation of Hospitals has approved a hospital directed and operated by only one physician! The Maynard MacDougall Memorial Hospital in Nome, Alaska, a 25 bed institution, was given full accreditation recently. The hospital is run by the women's division of Christian service of the Board of Missions of the Methodist Church. Its medical director and only physician is Dr. Fred M. Langsan, a general practitioner.

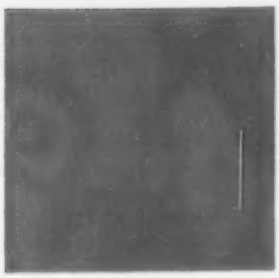
"The hospital," said Dr. Kenneth B. Babcock, commission director, "was surveyed and found to be in excellent condition, clean and sanitary throughout, with a cheerful, friendly atmosphere pervading the entire institution."

Kansas Association Elects Robert Molgren President

TOPEKA, KAN. — Newly elected president of the Kansas Hospital Association is Robert A. Molgren of the University of Kansas Medical Center, Kansas City. President-elect is Roger B. Samuelson of Susan B. Allen Memorial Hospital, El Dorado. Re-elected were: vice president, Sister M. Roberta of St. Elizabeth's Mercy Hospital, Hutchinson, and treasurer, Fred M. Walter of the Atchison, Topeka and Santa Fe Hospital, Topeka.

Arizona Officers Elected

TUCSON, ARIZ. — The Arizona Hospital Association elected the following officers at its annual convention here: president, Guy M. Hanner, administrator, Good Samaritan Hospital, Phoenix; vice president, James L. Kline, administrator, Gila County Hospital, Globe; secretary-treasurer, H. F. Hancox, administrator, John C. Lincoln Hospital, Sunnyslope.



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"Gypsona" Plaster of Paris Bandages are now available in all 48 states through Surgical Supply Dealers. They are made in a wide variety of sizes to fit your every need.

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Administrator Loses in Public Appeal for Job Reinstatement in Alabama

ANNISTON, ALA.—The Civil Service Board here ruled against Murphy Cole, former administrator of Memorial Hospital, following seven days of public hearings here last month.

Mr. Cole had appealed his discharge by hospital trustees last August.

The board found that Mr. Cole was guilty of 17 out of 21 charges of inefficiency brought against him by hospital trustees. The decision was unanimous, and the chairman said it was a difficult decision for the board, because all three of its members "are personal friends of Mr. Cole and hold him in high esteem."

Members of the Civil Service Board are a local florist, a barber, and the wife of an Anniston factory's sales manager.

Hospital trustees who discharged Mr. Cole last August after eight years as administrator of the hospital included a retired army officer now in the insurance business in Anniston, a physician who was chairman of the hospital's medical staff at the time of Mr. Cole's discharge, a veterinarian, a merchant, and a woman member who served as board secretary.

Last August 1, Mr. Cole issued a bulletin to hospital employes stating that he had been relieved of his duties and responsibilities as administrator of the hospital. On the same day, hospital trustees issued a press release saying he had resigned.

A week later Mr. Cole appealed to the Civil Service Board, asking the board to consider a letter of resignation he had written "null and of no effect."

In his statement to the Civil Service Board, Mr. Cole said he had been advised by the chairman of the hospital's board of trustees at 11 a.m. on August 1 that his employment as administrator would terminate at 2 p.m. on that date, and that he had until that time to submit a letter of resignation.

"I feel the treatment I received was unfair and unwarranted," he added. Subsequently, the Civil Service Board allowed the resignation to be withdrawn and directed the trustees to file charges supporting their action.

During the hearings, the board heard statements by a number of doctors, hospital employes, auditors and others, relating to the efficiency of hospital operations.

The hearings were enlivened when one witness, an office employe, broke down while being questioned, and another, the hospital's engineer, died of a heart attack in the hearing room. At the time, the engineer was waiting to testify in refutation of a trustee's assertion that hospital purchases had been "unnecessary and wasteful."

A number of hospital employes testified that Mr. Cole was "devoted to his work, cooperative and willing to help."

In his own testimony, Mr. Cole described his education, employment record, and membership in professional associations and organizations.

Witnesses on both sides agreed the hospital's accounts and financial records were in good order.

Following the board's ruling, Mr. Cole's attorney said, "We are examining the decision and reviewing the proceeding, and until completing this study we cannot make an announcement as to an appeal."

An appeal would take the case into the circuit court, it was indicated.

Blood Bankers Honor Dr. Richard Lewisohn

CHICAGO. — Dr. E. E. Muirhead, professor of pathology and chairman of the department at the University of Texas-Southwestern Medical School, Dallas, Tex., and chief of the department of pathology at Parkland Memorial Hospital, was named president-elect of the American Association of Blood Banks at the eighth annual meeting of the association here last month.

Dr. Muirhead will succeed Dr. James J. Griffitts, associate director of the Medical Research Foundation of Dade County, Miami, Fla., who became president of the association at this meeting.

Marjorie Saunders, director of public relations, Baylor University Hospital, Dallas, was reelected secretary of the association.

Dr. Richard Lewisohn, retired surgeon who practiced at the Mount Sinai Hospital in New York for many years, was presented with the Karl Landsteiner Award in Blood Banking "for his distinguished contribution to the field in discovering the use of sodium citrate as an anticoagulant."

Offer Course in Hospital Accounting by Mail

ROCHESTER, N.Y. — A correspondence course in hospital accounting has been prepared by the American Association of Hospital Accountants in conjunction with Indiana University. The course, now available, consists of 20 written assignments with readings in a recognized elementary general accounting text. Two hundred and fifty additional pages which apply general accounting fundamentals to hospital accounting supplement the text.

Where special problems of procedure and terminology occur, discussion material is provided to bridge the gap between the commercial and hospital approach. The student does not need a previous knowledge of accounting, but would be prepared, if he wished, to take a second semester of general accounting after completing the course, an announcement from the association said.

Assignments, both accounting problems and essay questions, are completed by the student at home. Papers are graded and returned to him with corrections and comments by the instructor.

Subject matter of the course is outlined as follows: basic principles of accounting, special journals and ledgers, patients' accounts receivable procedures, prepaid and accrued income and expenses, accounting for the payroll, hospital equipment records and depreciation, accounting for cash and internal control, financial statements, hospital accounting practice set.

In the future, other courses in the field of hospital accounting will be offered. Areas to be covered include the voucher system, departmental accounting, hospital investments, statement analysis, and cost accounting.

The importance of adequate training in hospital accounting is indicated in this comment by a leading hospital administrator:

"The green shade days of hospital accounting are gone forever; the present-day hospital accountant, with cost reports, budgets, food cost controls, and so forth, has within his province an opportunity to make a real contribution to hospital administration. Whether your accounting is progressive and a real tool of your management or whether it is merely recording figures for posterity is up to you. There's a job to be done . . . and it ought to be done right!"

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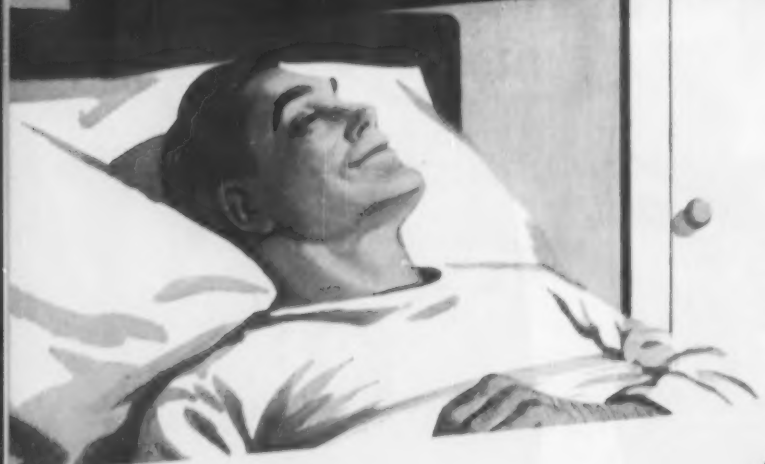

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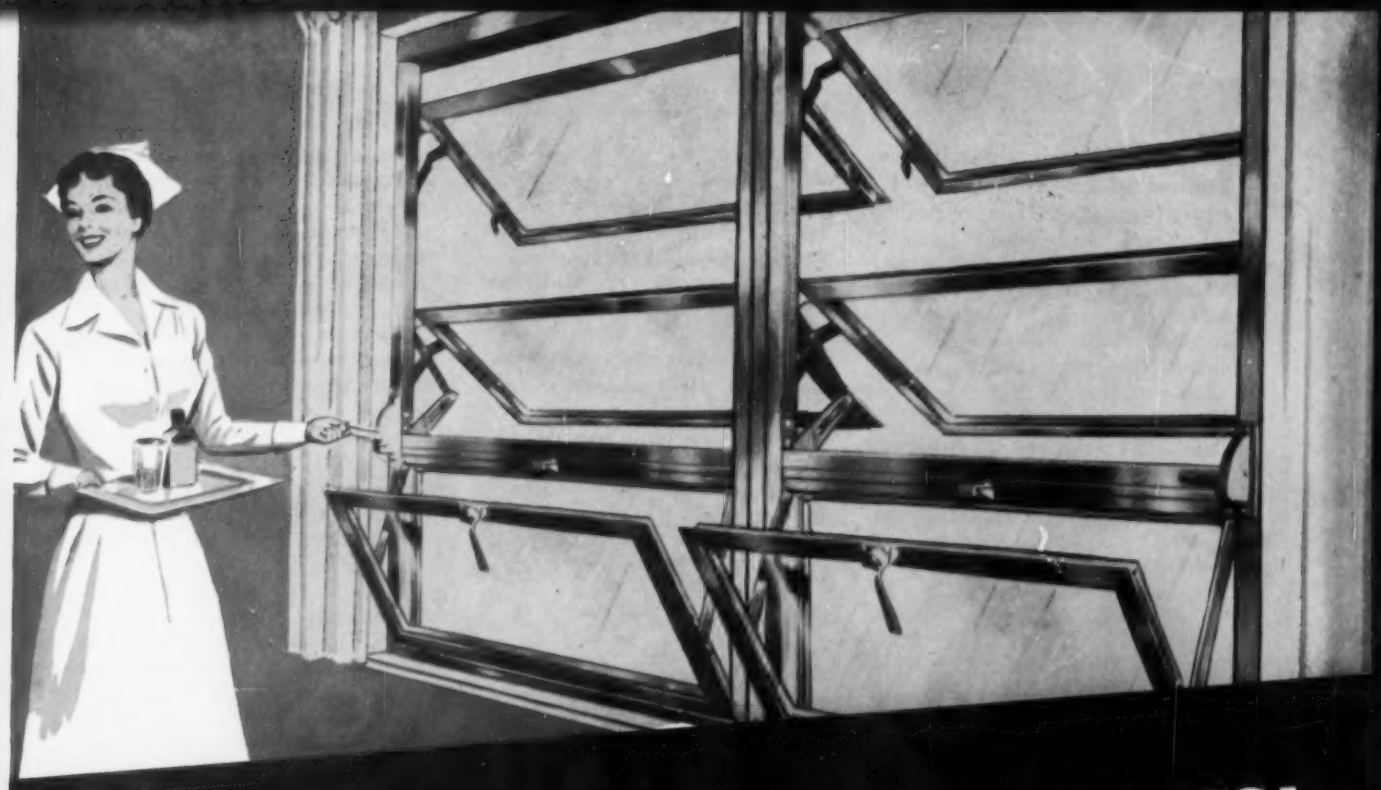

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A.S.T.A. Meeting Features Technical Exhibits and Maintenance Workshops

CHICAGO. — A sellout of exhibit space featured the third technical exhibit held in connection with the semiannual meeting of the American Surgical Trade Association here last month. Open for two days, the exhibits were crowded from early morning to the closing hour.

"This exhibit," said a prominent manufacturer of equipment used in hospitals, "is the finest our company attends. It gives us a splendid opportunity to explain our equipment to dealer salesmen."

The opening general session featured an address by Joseph P. Meek, president of the Illinois Federation of Retail Associations. Dale G. Deckert Sr., Deckert Surgical Company, Santa Ana, Calif., presided. Frank Rhatigan, association secretary, reported on progress to date for a proposed A.S.T.A. buying guide.

In discussing retail sales problems, Mr. Meek pointed out that continuation of growing discount practice on the part of A.S.T.A. members would lead many companies into a no-profit selling situation. "This will lead many of you into an inability to service your customer properly, or even into bankruptcy," he said. "If you all become price cutters, where will your customers get service?"

The closing day of the meeting was featured by a popular innovation in the form of service shops run by manufacturers for the benefit of dealer salesmen. Approximately 300 salesmen and owners of hospital and surgical equipment and supply houses attended the series of workshops. Attendance at these technical sessions ran from 10 to a high of 50.

Workshop participants heard explained some of the mysteries of electronics, physics, electricity, mechanics, hydraulics, and many other technical phases involved in the operation of all kinds of professional and nonprofessional equipment sold through surgical dealers. The aim of the lecturers and demonstrators at the workshops was to equip dealer salesmen better to give prompt maintenance service to equipment used in hospitals, it was explained.

It was apparent from many remarks of technical experts from manufacturers and dealer salesmen that few hospitals have a realistic program of preventive maintenance. Because of this lack of good hospital maintenance programs, dealers are called upon for much unnecessary and economically wasteful service, they reported. The hope was expressed in many of the sessions that these workshops would equip dealer salesmen to explain to hospital executives the need for and the type of preventive maintenance which would cut the cost of operating complicated equipment.

At a meeting of the board of directors of A.S.T.A. held on the day following these workshops, a decision was made not only to continue them next year but to increase the time allotted to two full days. Everyone concerned with the development and operation of the workshops felt that this move represented a major effort on the part of A.S.T.A. and its member dealers and manufacturers to improve the operation of hospitals.

Edward Heyd, administrator of Children's Hospital, Cincinnati, was the featured speaker at the service workshop luncheon. He discussed "The Service Man and His Job," and emphasized that sales and service can never be separated.

(No. 80-62 PRIVATE ROOM GROUPING)

Another Hill-Rom First—series 8,000 hospital furniture

color styled by Howard Ketcham

Hill-Rom
Contemporary
FURNITURE FOR THE MODERN HOSPITAL

● This beautiful private room grouping is a happy combination of the traditional and the modern in hospital furniture design and finish. A distinctive feature is the decorative line which curves gracefully across the panel parts to contrast pleasingly with the deep, luxurious finish of the wood as fashioned by our color expert.

All posts and framework are of solid maple. The panel work is cherry wood. Tops of chest desk, overbed table and bedside cabinet are high pressure laminate—cherry grained, heat and stain resistant. Although classed as a minimum priced suite, the 8,000 grouping is a Hill-Rom creation in every respect, which means it has been built for value and durability as well as for smartness and beauty.

Shown in the 80-62 Private Room Grouping above are: No. 80-62 Motor Hilow Bed (listed by U.L. for use with oxygen) No. 8003 Bedside Cabinet, No. 80-614 Overbed Table, No. 80-26 Chest Desk, No. 8007 Straight Chair, No. 8008 Arm Chair, No. 306 Lamp and No. 300 Safety Sides. The No. 80-61 Manual Hilow Bed is also available with this grouping.

Write or wire for further information on this grouping.

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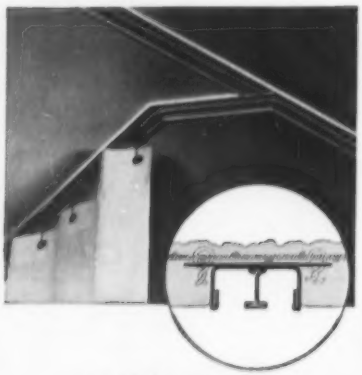

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Hill-Rom recessed-in-ceiling Perfected Screening provides for insertion of the track directly into the ceiling, leaving no exposed fixtures or projections. Designed primarily for use in new construction, or when remodeling is being done. The track is wired directly to the metal lath and stringers—before plastering. Plaster is applied flush with the track. Channel and track may be painted to match ceiling finish, making an installation that is hardly noticeable. This type of screening can also be used with accoustical tile applications.

STANDARD CURTAINS

By using the standard Hill-Rom screening unit (either type) one-size curtains are used throughout the building. This eliminates confusion when replacing curtains after laundering. Hill-Rom curtains are made of pre-shrunk, vat-dyed Cordette material, in 16′ width, length determined by ceiling height. The rollers are made of machined nylon, insuring quiet operation. Rollers and curtain hooks are assembled in one unit.

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Now you can have high back chair comfort for your patients—and wall-saver protection for your rooms—without having to put up with those big, heavy, hard-to-move, wall-damaging high back chairs of yesterday. For this new Hill-Rom Arm Chair, despite its small size, gives high-back comfort in full measure! See how easily the nurse adjusts the back cushion by using the elevating rack. Another exclusive feature is the fact that the undercovers on the cushions are waterproof and stain-proof, and easily cleaned. The slip covers are removable.

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In whitest white or clean, clear, wanted colors, there's a Barreled Sunlight Paint for every job

Michael Reese Dedicates Six-Story Kaplan Unit

CHICAGO.—Dedication of the M. S. Kaplan Pavilion of Michael Reese Hospital Medical Center here was held recently. The block long, six-story building of 112 beds, which cost $3.5 million, will ultimately become the central building of the medical center, hospital officials stated.

Speakers at the ceremony included Sen. Paul Douglas (D.-Ill.), Gov. William Stratton, Mayor Richard J. Daley, and other civic officials. The unit was officially opened by Mrs. M. S. Kaplan, widow of the man for whom the building has been named.

The new pavilion is located near the center of the patient area of the medical center. A bridge half a block long and a tunnel which extends for a quarter of a mile connect it with all other patient buildings.

On the four upper floors of the hospital addition are 112 patient beds, 28 to a floor, with 32 private rooms and 40 semiprivate rooms.

Most of the second floor is devoted to a new x-ray department for the entire medical center. Next to the x-ray department are four castrooms and a cast x-ray room.

The new six-story Kaplan Pavilion of Michael Reese Hospital, Chicago, for private and semiprivate patients.

The main floor is the focal point for many special services for the estimated 5000 people who come to Michael Reese daily, Dr. Morris H. Kreeger, executive director of Michael Reese, stated. Patients being admitted will be escorted to one of a bank of private room clerk's offices. Across the hall, every incoming patient will receive a routine chest x-ray. Adjacent are a bank of doctors' examining rooms. A gift shop, to be managed by the women's board, and a drug salesroom are located facing the lobby. One wing is set aside for administrative and accounting offices.

To accommodate the 550 doctors who practice at Michael Reese, the planners of the pavilion also built in a quarter block long section for their use, which includes a lounge, locker room, and mail boxes for all doctors. In this section are also five double rooms to augment the living quarters for doctors in training at Michael Reese.

At the tunnel level are three major services for the entire medical center. In the pharmacy, drugs will be manufactured and prescriptions filled for all of the 908 patients hospitalized in the medical center plus many of the estimated 55,000 outpatients who come to Michael Reese annually. A pneumatic tube system permits a pharmacist to dial the destination of the drug on the pneumatic tube and ensure the arrival of the prescription at the desired building in a matter of seconds. This pneumatic tube system will also be used to speed medical records and small nursing supplies to all patient buildings.

Architects for the project were Loebl, Schlossman and Bennett, Chicago.

Emory to Give Hospital Administration Course

EMORY UNIVERSITY, GA. — Emory University School of Business will initiate a graduate program of hospital administration in September. A $130,000 Kellogg Foundation grant will finance the course.

The program, which will lead to a master of business administration degree, will be composed of basic and advanced business courses plus a period of residence in a hospital.

Facilities of Emory and Crawford Long hospitals in Atlanta, which are owned by the university, and other hospitals in the area will be used for lectures and student observation.

Institute Graduates 38

WASHINGTON, D.C. — Thirty-eight administrators of U.S. federal hospitals and Canadian army and navy hospitals were graduated recently from the eleventh Interagency Institute for Federal Hospital Administrators here. The intensive three-week course in hospital administration was held late last fall, under the auspices of the Interagency Committee on Training and Education of Federal Hospital Administrative Personnel. The Veterans Administration sponsored the institute.

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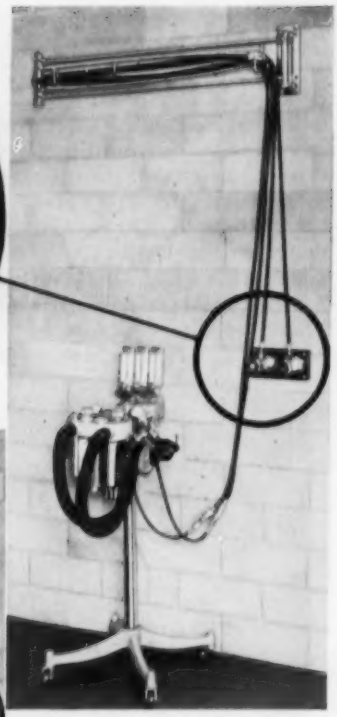

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Voluntary Hospitals Get Ford Grant

(*Continued From Page* 58)

ciation and all accredited colleges and universities, instead of selected institutions, was chosen to maintain "the desirable diversity of character among these institutions."

Dr. Edwin L. Crosby, director of the American Hospital Association, said he was called into consultation with foundation officials a short time before the gifts were announced.

About all they knew then was that the foundation was going to do something big for hospitals, Dr. Crosby reported. The details were worked out in less than three weeks. A.H.A. staff and facilities were used around the clock to develop the plan and compute amounts of the grants to more than 3500 listed hospitals, it was explained.

A number of possible methods of distributing funds to hospitals were considered and discarded before the final, all-inclusive plan was adopted, it was reported. Among these was a proposal that the grants should be limited to hospitals approved by the Joint Commission on Accreditation of Hospitals.

This plan was rejected, a spokesman said, because in many communities the only hospital care available is in institutions not yet accredited or not eligible for accreditation; the restriction would thus have cut off large groups of the population from receiving any benefit from the grants.

Terms of the grants to medical schools were still to be worked out by a special advisory committee, the foundation said, but it was indicated that all privately supported medical schools would be included, and the grants were to be used chiefly to strengthen instructional programs.

The broadside method also solved the foundation's problem of making a huge grant without the necessity for laborious, time consuming investigation of individual grantee institutions, it was explained. "Foundations channel the bulk of their money into large-scale projects and programs," said a recent article in *Fortune* magazine, describing this phase of foundation operation. "Academics joke privately (and bitterly) that it's easier to get $500,000 from a foundation than $5000."

In another magazine article, the Ford Foundation was described recently in relation to other foundations "as a whale is to a school of tuna fish."

"Why don't you boys just give everybody in the country two bucks apiece and quit?" the wife of a foundation executive was quoted by the *New Yorker* as having asked recently.

As the magazine then explained, the foundation had more than that to give away. Estimates placed the value of Ford Foundation holdings at $2.9 billion before the $500 million hospital-college grant.

Trustees of the Ford Foundation are: Henry Ford II; Benson Ford; H. Rowan Gaither Jr., president; Charles E. Wyzanski Jr., judge of the U.S. District Court, Boston; John Cowles, Minneapolis publisher; Mark F. Ethridge, publisher of the Louisville, Ky., *Courier-Journal;* Laurence M. Gould, president of Carleton College, Northfield, Minn.; Donald K. David, former dean of the Harvard Business School; Frank W. Abrams, former chairman, Standard Oil Co. of New Jersey; James F. Brownlee, New York investment banker; John J. McCloy, former U.S. High Commissioner for Germany, and Charles E. Wilson, former president of the General Electric Co.

Corridor of Klingenstein Pavilion, Mount Sinai Hospital, New York City, showing ceiling of Acousti-Celotex Incombustible Perforated Mineral Tile suspended on an Acousti-Line* System. Architect: Kahn and Jacobs, New York City. General Contractor: Thompson-Starrett Company, Inc. Acousti-Celotex Contractor: Jacobson & Company, Inc., New York City.

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Hospital patients need a quiet atmosphere to speed recuperation. In many of the nation's hospitals, this is achieved through ceiling installations of sound-absorbing Acousti-Celotex Tile. Thus, disturbing noises are checked in corridors, lobbies, kitchens, utility rooms . . . prevented from filtering into wards, nurseries, operating and delivery rooms. The resulting *quiet comfort* aids patients' recovery, personnel efficiency.

Economical and Effective—Acousti-Celotex Tile provides the low-cost and efficient answer to the noise problem. In the installation illustrated, the Acousti-Line suspension system permits easy access to the above-ceiling area for maintenance of wiring, plumbing and heating pipes, other utilities. The tile has high sound-absorption value, is quickly installed, needs no special maintenance. Its attractive surface can be washed *repeatedly* and painted *repeatedly* without loss of sound-absorbing properties.

An Acousti-Celotex Exclusive—Most important of all, you do not pay one dime for the most important part of Acousti-Celotex Sound Conditioning . . . 30 years of sound engineering experience—in acoustical installations of all types, under all conditions.

Mail Coupon Now for a Sound Conditioning Survey Chart that will bring you a *free analysis* of the noise problem in your hospital, plus a free factual booklet, "The Quiet Hospital." No obligation.

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Without cost or obligation, please send me the Acousti-Celotex Sound Conditioning Survey Chart and your booklet, "The Quiet Hospital."

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Hospital _____

Address _____

City _____ **County** _____ **State** _____

Michigan Association States New Policy

(*Continued From Page 90*)

our standards. Rather, I feel this association is a positive force in improving patient care, and to exclude a particular segment of our state's hospitals is to perform a disservice to those patients who patronize those hospitals.

"It has been suggested that such a move would affront our good friends, the Michigan State Medical Society. This I find hard to believe. Osteopathic and osteopathic-M.D. hospitals have been participating in Blue Cross for several years. Those physicians who are now practicing in combination hospitals have not been disciplined by the medical society. Regardless, I feel that fundamentally the Michigan Hospital Association should mean just that—an organization which is dedicated to improvement of standards for all hospitals."

Mr. Pattullo made it clear that he was presenting his own opinions only, and that his statement on osteopathic hospitals did not represent the opinion of the association's board of trustees.

Dr. A. C. Kerlikowske, University Hospital, Ann Arbor, was named president-elect of the association. He will succeed Mildred Riese, administrator of Children's Hospital, Detroit, who became president during the meeting, succeeding Mr. Pattullo.

Approximately 250 association members and guests attended the convention, Allan Barth, association secretary, reported.

Industrial Aid Program for Hospitals Launched by Chicago Hospital Council

CHICAGO. — The Chicago Hospital Council and the Chicago chapter of the Society for Advancement of Management have announced the establishment of a hospital industrial aid program for the Chicago area.

Under the program, services of industrial engineers and management experts who are members of the Society for Advancement of Management will be available to Chicago hospitals for studies of management problems, it was explained.

The program is comparable to the industrial aid program in New Brunswick, N.J., initiated by Johnson and Johnson two years ago, the hospital council said.

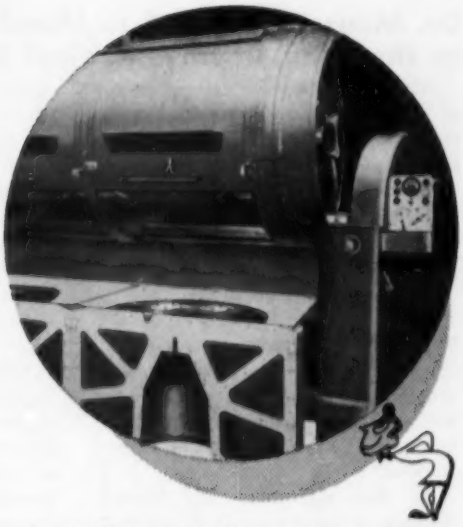
Henry J. Arends, president of the Chicago chapter of the society, said, "We selected hospitals as our special project because we recognized the great and essential service they perform for the community. Since their services are diverse, their management problems are challenging."

"We recognize that patient care, essentially a personal service, can never be put on the production line," said Carl K. Schmidt Jr., superintendent of Oak Forest Institutions, chairman of the hospital council committee planning the project, "but we also know we can learn a lot from industry in the operation of many of our service departments. All hospitals will be grateful for this offer of help."

Accountants Elect Donald Hamachek

CHICAGO. — Donald Hamachek, office manager of Passavant Memorial Hospital here, was elected president of the Illinois Chapter, American Association of Hospital Accountants. Mr. Hamachek succeeds Arthur W. Barron Jr., comptroller of the Franciscan Sisters of the Sacred Heart, Joliet, Ill.

raise the cylinder



Below. Shell and cylinder shown in raised position. Note complete accessibility of all working parts, including dump valve, to permit rapid maintenance.

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UNLOADING LAUNDRY WASHER
surpasses all others
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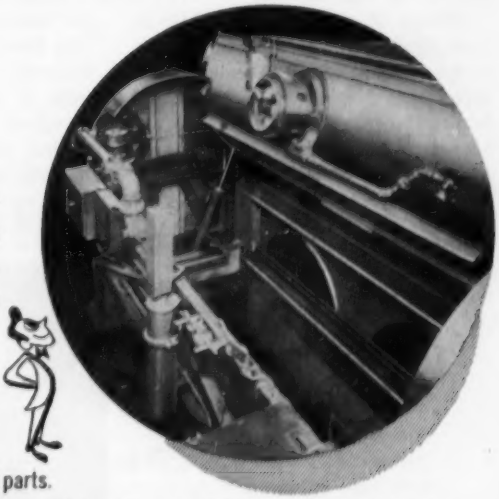
Other unloading washers *may claim* to increase your laundry production . . . but only HOFFMAN can deliver this promise. That's because HOFFMAN's simplified design *makes maintenance easy . . . speeds adjustments*—goes back into service quickly to keep right on increasing your production for the same floor area.



Below. Close-up of V-belt and chain drive, for washer drive. Ultra-simple to adjust and repair.

check these exclusive HOFFMAN features:

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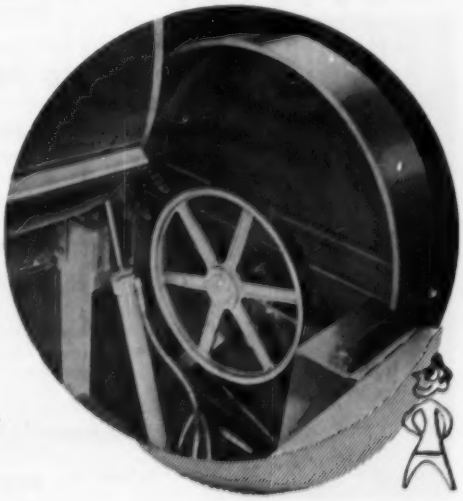

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Dr. Mousel Admitted to Membership in the King County Medical Society

SEATTLE. — Out-of-court settlement of the case of Dr. Mousel's salary at the Swedish Hospital here was assured December 5.

On that date the King County Medical Society reversed itself and voted, on advice of legal counsel, to admit Dr. Lloyd H. Mousel to membership.

That crucial hurdle surmounted, it appeared certain that the remaining steps would be taken to implement the settlement agreement signed Sept. 30, 1955, in Dr. Mousel's conspiracy suit against the county medical society and seven other professional organizations.

In that agreement, Dr. Mousel, director of anesthesiology at the hospital, agreed to drop his suit as soon as he was admitted to membership in two of the organizations.

Officers of the medical society, in turn, agreed to urge society members to accept him, and to recommend his acceptance by national professional bodies, provided the hospital discontinued paying him a salary for supervision of nurse anesthetists.

The society's vote, taken at the best attended meeting in its history, reversed the previous unyielding stand against him which had prevailed during the five-year controversy.

All parties to the settlement expressed satisfaction with the outcome of the vote.

It was a foregone conclusion that with his admission to the society, Dr. Mousel also would be admitted to the Washington State Society of Anesthesiologists, which also had denied him membership, at a meeting later in December, and that letters would be written by the trustees of the county society recommending his acceptance as a member by the Washington State Medical Association and the King County Medical Service Bureau, a physician sponsored prepaid medical care program.

There was no doubt, either, that the trustees would inform the American Board of Anesthesiology that Dr. Mousel's relationship with the hospital "is an ethical and proper one," as agreed.

Had the vote gone against Dr. Mousel again, the suit would have come up for hearing in the superior court in Seattle in January.

Under the agreement, it appeared that nothing in Dr. Mousel's arrangement with the hospital will be changed except the matter of his compensation for supervision of nurse anesthetists.

The one difference will be that the hospital hereafter will bill patients in Dr. Mousel's behalf for his supervisory fee, and will remit the fee to him, in addition to billing for its own expenses.

Dr. Mousel, meanwhile, will remain on salary for his teaching and administrative duties.

Dr. Clayton P. Wangeman, a member of associated anesthesiologists and one of the leaders of the opposition to Dr. Mousel's previous relation with the hospital, commented that the agreement "gave us what we wanted. We have stopped the corporate practice of medicine by the hospital."

Dr. Mousel, in turn, said, "I am extremely gratified that we have been able to reach this amicable disposition. I think it's a good result for me and I am sure we all will be able to work together professionally."

There was a round of applause in the meeting hall as the results of the vote on Dr. Mousel's application were read, although more than half of the 400 who voted had left by that time. The society has more than 1200 members.

The members voted after Michael K. Copass, attorney for the medical society, had told them failure to accept Dr. Mousel, in effect, would be "like Korea—a case of fighting the wrong war in the wrong place at the wrong time."

Mr. Copass said, "Even if this went to court, there would be no clear-cut decision on the issue you all would like decided, that of the corporate practice of medicine. This suit does not seek a definition of that practice; it seeks to establish that a conspiracy has existed, and that is all.

"In my opinion, the agreement that has been reached does more for the members of this society than a favorable court decision would, on these two grounds:

"It reconciles the divergent opinions on a basis that spells out the charges that are to be made by the hospital and by the doctors.

"And it is contingent on a determination on democratic principles, and not by court order, of whether you members want Dr. Mousel as a member." (*Continued on Page* 170)

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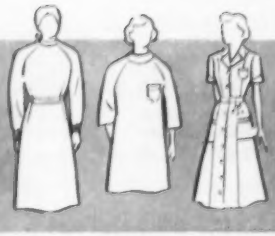

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(*Continued From Page 168*)

Mr. Copass said, "We already have made progress in settling the differences. For example, I think it was progress when Dr. Daniel C. Moore (one of the defendant anesthesiologists) sponsored Dr. Mousel's application for membership.

"As your counsel, I urge you to take the final step and vote Dr. Mousel in."

The vote followed. Exact results were not announced, but a four-out-of-five margin is required for acceptance.

Dr. Frederick A. Tucker, president of the society, said, "We are happy to welcome Dr. Mousel to membership. After long and careful study, we have been able to work out a solution in which the interests of all concerned have been protected."

Jack R. Cluck, Dr. Mousel's attorney, expressed satisfaction with the outcome of the case, which he described as "one presenting interesting problems on the frontiers of both law and medicine."

He said the agreement embodied "both sides' insistence that the safety of the patient must be paramount."

Edna K. Huffman Cited for Services to Medical Record Library Field

EVANSTON, ILL. — More than 70 people from the Chicago Association of Medical Record Librarians and others interested in medical record library work gathered at the Evanston Hospital here November 16 to honor Edna K. Huffman, former president of the American Association of Medical Record Librarians.

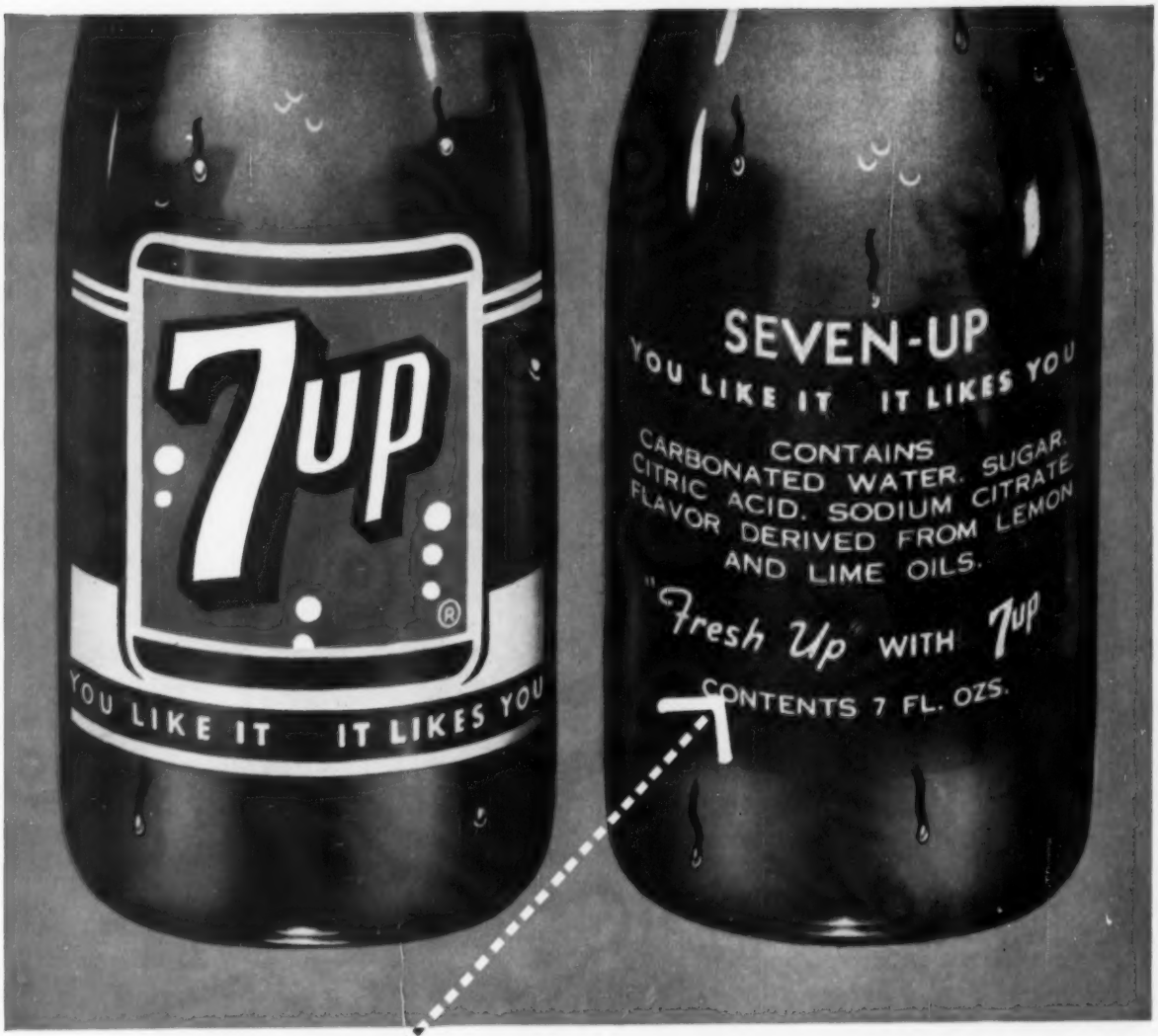
Everett W. Jones, vice president of the Modern Hospital Publishing Company, Chicago, briefly outlined Mrs. Huffman's many accomplishments in the field. She became a member of the association two years after its organization in 1928 and served as its president in 1934 and 1935. She also served as a field representative and editor of the record librarians' journal over a period of several years.

Mrs. Huffman organized and directed schools for the medical record librarians at St. Joseph's Hospital, Grant Hospital and Wesley Memorial Hospital, Chicago. In 1949 she spent several months in Australia at the invitation of the Australia Hospital Association, to serve as a consultant and to conduct institutes for medical record library personnel in that country. She is currently a lecturer in medical record librarian science for the Program in Hospital Administration, Northwestern University.

Hospitals Criticized: Not Human Enough; Expensive

KANSAS CITY, MO. — The public thinks hospitals cost too much and are not sufficiently concerned with their patients as human beings. These opinions were noted in a survey of 1000 persons in an industrial city in the northeastern U.S., reported at the 83d annual meeting of the American Public Health Association.

Eighty-two per cent of those interviewed thought hospital costs were too high and 71 per cent thought hospital care was unsatisfactory. Reporting on the survey, Earl Lomon Koos, professor of social welfare at Florida State University, commented that hospitals were "caught in the coils of advancing medical technology." But many of the current ills in hospital-patient relations exist simply because the patient has been somewhat forgotten in the course of hospital progress, he said.



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The source of the 7-Up flavor is a fragrant, natural oil in the peel of lemons and limes. From every batch of this flavor source, Seven-Up selects less than 5% , *the very essence*, as being delicate and pure enough to be used in the "fresh up" drink! Seven-Up is crystal-clear. No artificial flavor is used.

If you want a real thirst-quencher . . .

If you hanker for a cool, clean taste . . .

If you want a quick, refreshing lift . . .

Nothing does it like Seven-Up!

Iowa Hospitals Will Appeal Court Ruling

(*Continued From Insert Op. Page 49*)

Goldwater case is the law of this case now before the court, then the plaintiff hospital must prevail and would have the right to hire medical specialists in all fields of medicine, including having surgeons on salary.' It is our judgment that the ruling of the Goldwater case should prevail, so far as hospital laboratories and x-ray departments are concerned. It is the one case that is in point in this controversy."

Addressing the assembly, Herschel Langdon, law partner of Judge Herrick, expressed a strong opinion that the court's decision is wrong and pointed out, "Remember, this is the opinion of just one judge." He said the decision has great national significance in that it is the first decision of any court on the particular question involved in this case.

Mr. Langdon continued, "No one will know for sure who is right or wrong until the nine judges of the state supreme court have rendered a decision. We think that to acquiesce in the opinion of the district court would be worse than being defeated in the supreme court."

Mr. Langdon then explained that the hospitals could not go to the legislature appealing for a change in the law without a decision from the supreme court.

John Powers of Detroit, Mich., attorney for nine Catholic hospitals in Iowa, said that none of these hospitals intends to "sell, lease or give away any space" to physicians. "Once you open the doors, the tax boys will walk in," he declared.

Glen Gross, Lake City, a hospital administrator, asked why hospitals couldn't simply close their laboratories and put the problem in the physicians' laps. Within a week, "they'd be screaming for mercy," he predicted.

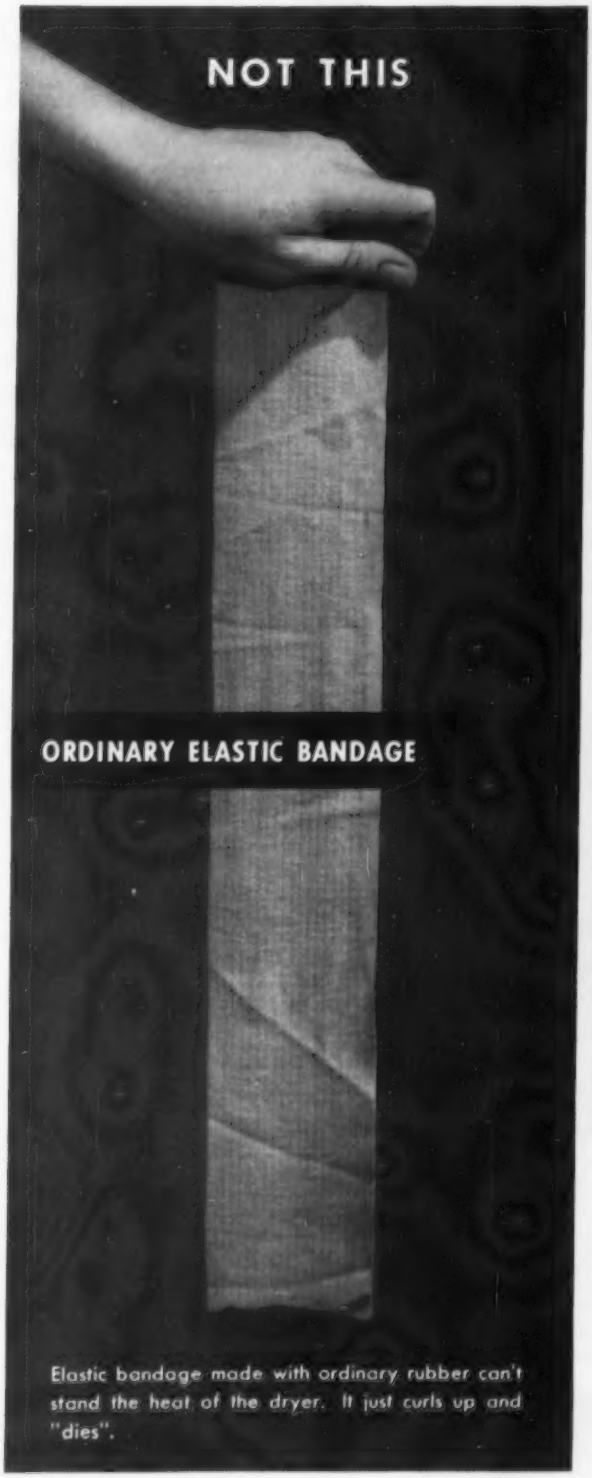
Louis Blair, administrator of St. Luke's Methodist Hospital, Cedar Rapids, discussed the practical effects of the district court's decision on hospital administration. He pointed out that all services ordered by a physician must be provided in an orderly fashion. "Many procedures," he said, "such as x-ray and laboratory examinations require nursing care before and afterward. Heretofore, all nurses and technicians have been coordinated through the hospital organization and motivated by the hospital's objective of smooth, efficient and sympathetic care. If various groups of technicians become the employes of separate employers, efficient hospital care will be made difficult or impossible."

In discussing multiple billings, Mr. Blair said, "The district court opinion refers specifically only to laboratory and x-ray service. However, its implications are broader and the Iowa State Medical Society is on record as stating that in addition to x-ray and laboratory, anesthesia, anesthetic materials, EKG's, physical therapy and oxygen therapy are also medical services which should be billed in the name of a physician."

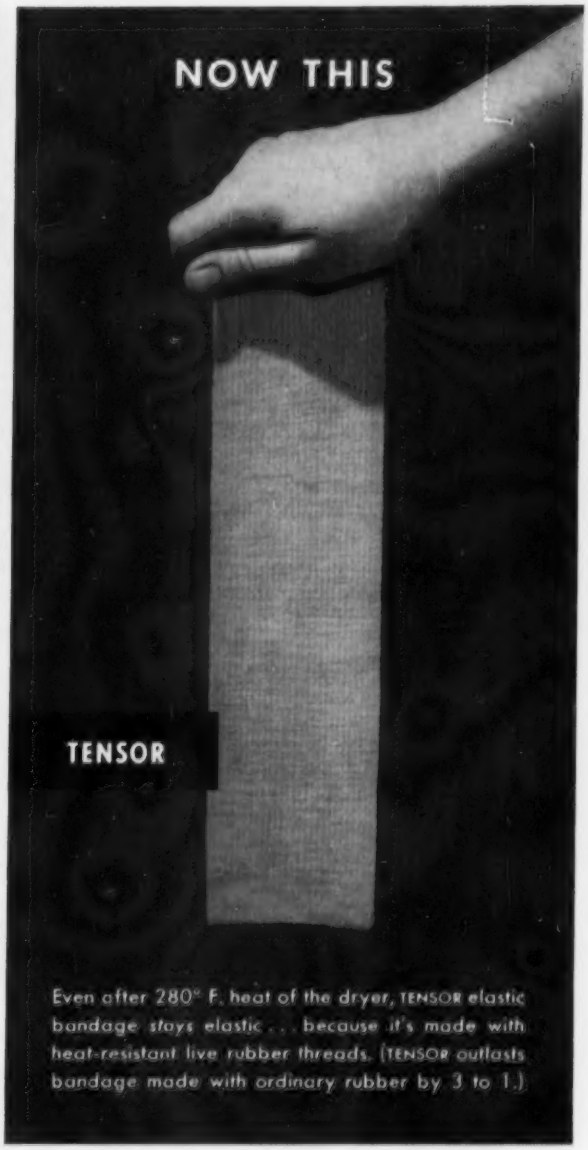
Mr. Blair also discussed internal complications and the cost of separate billings for these services. He said, "Patients not having insurance will receive from one to four additional bills. An analysis of 500 accounts at St. Luke's Hospital proves this point."

Group discussion before and after the general assembly meeting laid great emphasis on the bad effects of the court ruling from the standpoint of selling both commercial hospital insurance and Blue Cross plans.

NEW TENSOR DOESN'T "DIE" IN THE DRYER



Elastic bandage made with ordinary rubber can't stand the heat of the dryer. It just curls up and "dies".



Even after 280° F. heat of the dryer, TENSOR elastic bandage *stays* elastic . . . because it's made with heat-resistant live rubber threads. (TENSOR outlasts bandage made with ordinary rubber by 3 to 1.)

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ELASTIC BANDAGE

WOVEN WITH HEAT-RESISTANT LIVE RUBBER THREADS

BAUER & BLACK

Division of The Kendall Company
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Hospital Council Names W. K. Klein New President

BROOKLYN, N.Y. — The Hospital Council of Brooklyn, Long Island and Staten Island has elected William K. Klein of the Long Island College Hospital president for the ensuing year. Serving with Mr. Klein will be president-elect, George N. Johnson, Evangelical Deaconess Hospital; vice president, Melvin H. Dunn, St. John's Episcopal Hospital; secretary, S. L. Moody, Carson C. Peck Memorial Hospital, and treasurer, Vernon Stutzman, Methodist Hospital.

James Russell Clark, Brooklyn Hospital; Arthur Feigenbaum, Jewish Chronic Disease Hospital, and Dr. Harvey Gollance, Coney Island Hospital, were elected to the executive committee.

$1 Million to Hospital Fund

CINCINNATI. — Trustees of the Procter & Gamble Fund recently announced a $1 million gift to Greater Cincinnati Hospital Funds, Inc. This is the largest single contribution to date toward the funds' campaign goal of $17.5 million to improve and expand 11 nonprofit hospitals in the Cincinnati area.

COMING EVENTS

ALABAMA HOSPITAL ASSOCIATION, Annual Convention, Tutwiler Hotel, Birmingham, Jan. 26, 27.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRAIORS, Annual Meeting, Palmer House, Chicago, Sept. 15-17.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRAIORS INSTITUTES: Tenth Southern, University of Tennessee, Memphis, Jan. 9-13; Minnesota, University of Minnesota, Minneapolis, Feb. 20-24; 24th Chicago, University of Chicago, Sept. 4-14; 7th Chicago Advanced, University of Chicago, Sept. 10-14; Educational Conferences: Belmont Plaza Hotel, New York, Feb. 13-17; Congress Hotel, Chicago, Mar. 12-16.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, Palmer House, Chicago, Sept. 17-20; Midyear Conference for Presidents and Secretaries of State Hospital Associations, Palmer House, Chicago, Feb. 6, 7.

AMERICAN HOSPITAL ASSOCIATION INSTITUTES: Hospital Volunteer Service, Chicago, Jan. 5, 6; Organization Planning, Highland Park, Ill.; Jan. 16-18; Accounting and Business Practices for Small Hospitals, Houston, Tex., Jan. 23-27; Evening and Night Nursing Service, Chicago, Jan. 30-Feb. 2; Hospital Personnel, Kansas City, Mo., Feb. 13-17; Hospital Planning, Washington, D.C., Feb. 13-17; Financial Management and Accounting Control, Chicago, Feb. 13-17; Hospital Laundry Management, Boston, Feb. 15-17; Supervisory Training Workshop, Boston, Feb. 27-Mar. 2; Nursing Service Administration, Portland, Ore., Feb. 27-Mar. 2; Medical Record Library Personnel, Salt Lake City, Utah, Mar. 12-16; Dietary Department Administration, Chapel Hill, N.C., Mar. 12-16; Hospital Laundry Management, Atlanta, Ga., Mar. 20-22; Central Service Administration, Buffalo, N.Y., Mar. 26-29; Hospital Engineering, Atlanta, Ga., April 2-6; Operating Room Administration, Nashville, Tenn., April 9-12; Medical Social Workers, Chicago, April 9-13; Hospital Insurance, Kansas City, Mo., April 23, 24; Occupational Therapy, St. Louis, April 23-27; Hospital Auxiliary Leadership, Seattle, April 24, 25; Hospital Law, Atlantic City, N.J., May 14, 15; Insurance for Hospitals, San Francisco, May 31-June 1.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, St. Louis, Feb. 8-10.

ASSOCIATION OF WESTERN HOSPITALS, Olympic Hotel, Seattle, April 23-26.

BLUE CROSS PLANS, Annual Conference, Hollywood Beach Hotel, Hollywood Beach, Fla., April 8-12.

CALIFORNIA HOSPITAL ASSOCIATION, San Jose, Oct. 24-26.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 12, 13.

CATHOLIC HOSPITAL ASSOCIATION, Public Auditorium, Milwaukee, May 21-24.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Hotel Claridge, Atlantic City, N.J., May 16-18.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Convention Hall, Atlantic City, N.J., May 16-18.

IOWA HOSPITAL ASSOCIATION, Hotel Savery, Des Moines, April 26.

KENTUCKY HOSPITAL ASSOCIATION, Hotel Phoenix, Lexington, April 3-5.

LOUISIANA HOSPITAL ASSOCIATION, Jung Hotel, New Orleans, May 24, 25.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D.C., Oct. 31-Nov. 2.

MASSACHUSETTS HOSPITAL ASSOCIATION, Statler Hotel, Boston, May 10.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 17, 18.

MID-WEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, Mo., April 25-27.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Hotel Jefferson, St. Louis, Feb. 8, 9.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler Hotel, Boston, March 26-28.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 16.

NEW MEXICO HOSPITAL ASSOCIATION, Hilton Hotel, Albuquerque, March 12-14.

NORTH DAKOTA HOSPITAL ASSOCIATION, Grand Pacific Hotel, Bismarck, April 24, 25.

OHIO HOSPITAL ASSOCIATION, Deshler-Hilton Hotel, Columbus, April 9-12.

PUERTO RICO HOSPITAL COUNCIL, Caribe Hilton Hotel, San Juan, Jan. 15.

SOUTH CAROLINA HOSPITAL ASSOCIATION, Wade Hampton Hotel, Columbia, Jan. 21.

SOUTHEASTERN HOSPITAL CONFERENCE, Miami Beach, Fla., April 18-20.

TENNESSEE HOSPITAL ASSOCIATION, Hotel Claridge, Memphis, June 21-23.

TEXAS HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Dallas, April 3-5.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 30-May 3.

UPPER MIDWEST HOSPITAL CONFERENCE, Nicollet Hotel, Minneapolis, May 23-25.

WISCONSIN HOSPITAL ASSOCIATION, Hotel Schroeder, Milwaukee, March 15.

WORLD CONFEDERATION FOR PHYSICAL THERAPY, Second Congress, Statler Hotel, New York, June 17-23.

Chamberlin Psychosecurity Screens

PERMANENTLY AND SAFELY SOLVE PROBLEMS OF DETENTION

PREVENT ACCIDENTS AND ESCAPE

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PROVIDE PATIENTS' PEACE OF MIND

EASY TO INSTALL ON ANY WINDOW

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WHERE PROTECTION AND DETENTION ARE NEEDED

Patients rooms	Disturbed wards	Examination rooms	Treatment rooms
Corridors	Alcoholic wards	Waiting rooms	Windows accessible to prowlers
Solariums, day rooms	Nurses' stations	Delivery rooms	
Toilet rooms	Observation rooms	Emergency rooms	

3 CHAMBERLIN SCREENS MEET THESE NEEDS

(A) Detention Type (B) Protection Type (C) Safety Type

(A) DETENTION TYPE to withstand the fury of violent attack.

(B) PROTECTION TYPE for the less violent patient.

(C) SAFETY TYPE for mildly disturbed patients requiring protective custody.

OVER 100,000 IN USE

CHAMBERLIN HAS INSTALLED MORE PSYCHOSECURITY SCREENS THAN ALL OTHER COMPANIES TOGETHER

SUPERIOR ADVANTAGES

- *NO STEEL BARS*—ordinary screen appearance implies no sense of restraint—presents no prison look.
- *ALL STEEL FRAMES*—shock-absorbing stainless steel mesh is suspended to the heavy steel frame by concealed springs.
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Illinois Hospital Group Elects Leon Pullen

(*Continued From Page 154*)

with the difference between a fully accredited and nonaccredited hospital and to work with their hospital team for full accreditation.

John Eller, administrator of the Bethany Sanitarium and Hospital, Chicago, and chairman of the hospital association joint committee on job opportunities in hospitals, discussed help that auxiliary members could give hospital administrators in recruiting the best possible workers for all levels of jobs in hospitals. "Few people realize the wide range of skilled and unskilled positions in our hospitals," he said. Mr. Eller urged all hospital auxiliary members to familiarize themselves with hospital job opportunities.

Earl S. Planty of the University of Illinois discussed hospitals and human relations at a luncheon session. "There is too great a difference between the level at which we work and the level at which we could and should work," Mr. Planty said. He pointed out that the biggest job of executives, supervisors and other leaders is to produce a climate which makes people grow bigger in their jobs. "Do your employes know what your goals are? People like shared goals," he said.

Leonard P. Goudy, administrator of Proctor Community Hospital, Peoria, told the Illinois group that the state had been selected by the American Nurses' Association for a demonstration of its economic security project. He pointed out that an attorney trained in labor relations has been employed by the American Nurses' Association and that this man is now working with hospital nurses in Peoria. In two of the three Peoria hospitals the A.N.A. organizer has succeeded in getting a majority of the nurses to designate the Illinois Nurses' Association as their bargaining agent, Mr. Goudy reported. He added that despite a letter from the I.N.A. requesting a meeting to discuss nurses' professional problems in hospitals, the hospital administrators of Peoria have not as yet granted the request for this meeting. Instead, they replied to the request, asking for an itemized agenda of exactly what it is the nursing association wants to discuss. The hospitals have had a meeting with representatives of the newspapers in Peoria but so far no general publicity has resulted from the efforts of the nursing organizers, he reported.

In the discussion following Mr. Goudy's presentation, Dr. Klicka pointed out that there is at least one good point about a statewide bargaining setup. He said: "It results in uniform wage patterns for nurses in all hospitals and tends to eliminate competition in wages in an effort to attract more nurses to any given hospital."

Leon Pullen, administrator of the Decatur Macon County Hospital, Decatur, and chairman of the committee on insurance, fire prevention and safety, predicted that rates on liability and malpractice insurance would be increased within the next year by approximately 50 per cent. He used this fact as a reason for hospitals to pay increased attention to accident prevention and the adoption of standards used by the Joint Commission on Accreditation of Hospitals. Accident prevention programs and full accreditation are two of the best ways to get a reduction in liability and malpractice insurance, said Mr. Pullen, who was named president-elect of the association during the meeting. Leonard Hamblin, administrator of Bless-

ing Hospital, Quincy, took over the office of president from Wendell Carlson, administrator, Englewood Hospital, Chicago. Other officers elected were: Rev. John Weishar, Peoria, director of Catholic Hospitals, Diocese of Peoria, reelected first vice president; Dr. Stephen Manheimer, Chicago, director of Mount Sinai Hospital, reelected second vice president, and Delbert L. Price, Chicago, administrator of Children's Memorial Hospital, secretary-treasurer, succeeding Veronica Miller of Chicago, who recently retired.

New trustees are: Charles R. Freeman, Alton, administrator of Alton Memorial Hospital, and Dr. Morris H. Kreeger, Chicago, executive director of Michael Reese Hospital, both elected for three-year terms; and Virgil W. Nelson, Chicago, superintendent of Lutheran Deaconess Hospital, elected to fill an unexpired two-year term. Mr. Carlson and Mr. Hamblin were elected as delegates to the American Hospital Association, and Dr. Kreeger and Mr. Freeman were elected as alternate delegates.

Meeting just prior to the convention of the Illinois Hospital Association, the Illinois Conference of Catholic Hospitals convened in Springfield. This was the fourth annual conference of the Catholic group. Elected as officers were: president, Sister M. Anselma of St. Mary's Hospital, Kankakee; vice president, Sister M. Priscilla of St. Joseph's Hospital; secretary, Sister Rita Clare of Kankakee, and treasurer, Sister M. Clara of Joliet.

Reports Overcrowding in New York Mental Hospitals

NEW YORK. — New York State's mental hospitals are 25 to 30 per cent overcrowded, and overcrowding is increasing all the time, Dr. Paul H. Hoch, state commissioner of mental hygiene, declared recently in a television appearance.

Dr. Hoch said there were 116,000 patients in the state's mental hospitals, an increase of 3000 over the previous year. He suggested a broad, statewide program aimed at relieving the problem, including:

1. Intensified treatment in state hospitals.
2. State-aided psychiatric clinics and other community facilities.
3. A program of research into causes and treatment of mental illness.
4. Expanded training for psychiatrists to ease personnel shortages in state hospitals and other facilities.

The commissioner said the state would spend $350 million for construction of four new institutions to relieve overcrowding, and, under the state's new community mental health services act, communities would receive state aid to finance mental health facilities and clinics.

More Hospital Births

NEW YORK.—Hospital births are definitely on the increase. More than 9 out of 10 babies in the United States were born in hospitals in 1952, according to a report of the Metropolitan Life Insurance Company. The proportion, which in 1952 represented about 3,530,000 hospitalized births, has risen appreciably since that year, states the report. Between 1940 and 1952, the proportion of hospitalized births in the white population increased from 59.9 to 95.7 per cent; the percentage among nonwhites in this same period increased from 26.7 to 66.4.

ABOUT PEOPLE

(*Continued From Page* 82)

Dr. Gerald F. Houser

Dr. Gerald F. Houser has resigned as director of Faulkner Hospital, Boston, to become associated with **Dr. Anthony J. J. Rourke,** hospital consultant in New Rochelle, N.Y. Dr. Houser has served as superintendent of the American Red Cross at Harvard Hospital, England, instructor in psychiatry at Tufts College Medical School and Boston University School of Medicine, and has taught preventive medicine at Harvard Medical School. He also served as first assistant director at Massachusetts General Hospital, Boston.

Dr. Claris Allison has been appointed to the newly created position of assistant superintendent at Pierce County Hospital, Tacoma, Wash.

Sister Loretta Agnes, R.N., assistant administrator of All Souls Hospital in Morristown, N.J., has been named assistant administrator of Good Samaritan Hospital, Suffern, N.Y.

Crissy Anderson, R.N., has been appointed superintendent of Lindsborg Community Hospital, Lindsborg, Kan., succeeding **Elmer Ahlstedt.**

Ralph Hose, administrative assistant at Pontiac General Hospital, Pontiac, Mich., has been named assistant controller at Albert Einstein Medical Center, Philadelphia.

Albert Kelso has been named manager of Coulee Dam Community Hospital at Coulee Dam, Wash.

Joseph A. Conner has been appointed administrator of Sid Peterson Memorial Hospital, Kerrville, Tex. Mr. Conner has been administrator, Polly Ryon Memorial Hospital, Richmond, Tex.

E. D. Cramer has resigned as administrator of Wilson County Hospital, Neodesha, Kan., to accept the position of controller at Children's Mercy Hospital, Kansas City, Mo.

Glenn Kenley is now administrator of Winkler County Hospital, Kermit, Tex. Mr. Kenley was formerly assistant administrator at the Clinic Hospital, San Angelo, Tex.

Charles A. Miller is now administrator of McAlister Clinic, McAlister, Okla. Prior to his appointment, Mr. Miller was administrator of Medical Arts Hospital, Brownwood, Tex.

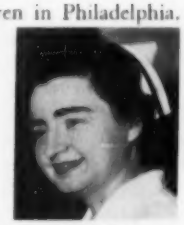
Jack Whitt has become administrator of McCalip-Ivy Hospital, Westlaco, Tex. He succeeds **Charles S. Thomas.**

Elmer W. Paul has resigned as administrator of Methodist Hospital, Lubbock, Tex. **The Rev. Wayne Cook,** chaplain, is acting administrator.

Norman Barnes, formerly associated with Brandon Inn, Brandon, Vt., is the new business manager at Silver Hill Foundation, New Canaan, Conn.

Department Heads

Frank Kent has been named director of public relations at St. Christopher's Hospital for Children in Philadelphia.



Helen C. Owens

Helen C. Owens has been appointed director of nursing services at Long Beach Memorial Hospital, Long Beach, N.Y. For the last 13 years, Miss Owens has been on the staff of Leroy Sanitarium, Inc., New York City. She has been superintendent of the sanitarium since 1952.

(*Continued on Page* 180)


Arthur D. Barnes

Arthur D. Barnes has been appointed superintendent of plant operations and construction at the Memorial Center for Cancer and Allied Diseases, New York. For the last eight years, Mr. Barnes has been administrative engineer at Johns Hopkins Hospital, Baltimore. Mr. Barnes holds a master of science degree from Pennsylvania State University and is a member of the American Hospital Association committee on engineering and maintenance.

Edward J. Morrison has been appointed director, personnel relations, at Highland View Cuyahoga County Hospital, Cleveland. Mr. Morrison was formerly director of public relations and personnel adviser at St. Peter's General Hospital, New Brunswick, N.J. During World War II he was director of personnel and control officer, with the rank of captain, at Walter Reed General Hospital, Washington, D.C. After separation from the service, Mr. Morrison served on a personnel survey team appointed by the surgeon general of the army. At the same time it was announced that **Gregory Repede** had been named director of the department of medical social service at Highland View. Mr. Repede holds a master's degree in social work from St. Louis University. Prior to his appointment, he was admitting officer and inpatient supervisor at Cleveland State Hospital.


Gregory Repede


E. J. Morrison

Evelyn Nelson has assumed her duties as director of nurses at Hinsdale Sanitarium and Hospital, Hinsdale, Ill. Mrs. Nelson was appointed to this position last year, following the resignation of **Mrs. Jessie Tupper-Walton,** and she has since been completing work on a master of science degree in nursing at the College of Medical Evangelists, Loma Linda, Calif.

June Malone, executive housekeeper of Beth Israel Hospital, Boston, has resigned that position to accept a similar post at Muhlenberg Hospital, Plainfield, N.J. Mrs. Malone is a past president of the National Executive Housekeepers Association, a member of the national board, and has been active in the affairs of the Massachusetts chapter of the association.

Rev. William R. Andrew has been named chaplain of the Clinical Center, the combined clinical and laboratory research facility of the National Institutes of Health, Bethesda, Md. The Rev. Mr. Andrew is the first full-time chaplain to serve the center. Prior to this appointment he was the chaplain and supervisor of clinical pastoral training at the Connecticut State Hospital, Middletown. He held similar positions in Illinois and New Hampshire state hospitals from 1945 to 1951. The Rev. Mr. Andrew is president of the Association of Mental Hospital Chaplains, and member of the Commission on Ministry in Institutions, National Council of Churches. He is also the author of several articles on clinical pastoral work.

Miscellaneous

Dr. Dean W. Roberts has been appointed executive director of the National Society for Crippled Children and Adults. Dr. Roberts is presently director of the National Commission on Chronic Illness and will assume his new duties as the work of the commission is completed. Previously, Dr. Roberts had served as deputy director of the state department of health and chief of the bureau of medical services in Maryland. He is a member of the American Public Health Association. Dr. Roberts succeeds **Lawrence J. Linck,** who has been executive director since 1945. Mr. Linck has been requested to continue to serve the society in the voluntary rôle of trustee-at-large and counselor.


Dean W. Roberts, M.D.


Lawrence J. Linck

Mary Elizabeth Tennant has been named associate professor of public health nursing at Yale University and will hold a joint appointment on the faculty of the Yale department of public health. Until her retirement

last June, Miss Tennant was assistant director in the division of medical education and public health of the Rockefeller Foundation. Miss Tennant is a fellow of the American Public Health Association and a life member of the National League for Nursing. During World War II she served as consultant to the Office of the Coordinator of Inter-American Affairs.

Henry R. Mason has been named survey administrator with the division of hospital facilities, Massachusetts Department of Public Health. Mr. Mason will have primary responsibility for the development of a statewide plan of priorities for the construction of chronic disease, diagnostic, treatment and rehabilitation facilities under the new Hill-Burton amendment. Prior to his appointment, Mr. Mason was secretary of the health and hospital division of the Council of Social Agencies in Syracuse, N.Y.

Edward A. Dougherty has assumed his duties as assistant director of the New Jersey Hospital Association. Mr. Dougherty holds a master's degree in hospital administration from the Institute of Administrative Medicine, Columbia University. He served his administrative residency at Princeton Hospital, Princeton, N.J. In his new position, Mr. Dougherty will be secretary of several of the association's councils and will work with the councils in developing and carrying out their programs.

George W. Warner has been appointed to the newly created position of administrative assistant to **Dr. Donald G. Anderson,** dean of the University of Rochester School of Medicine and Dentistry. Prior to his appointment, Mr. Warner served as administrative assistant to the associate director in charge of research at the National Cancer Institute, Bethesda, Md.

Norman C. Wilcox has assumed his duties as director of internal operations of Hospital Service of Southern California. He was formerly vice president of Health Service, Inc., Chicago.

Deaths

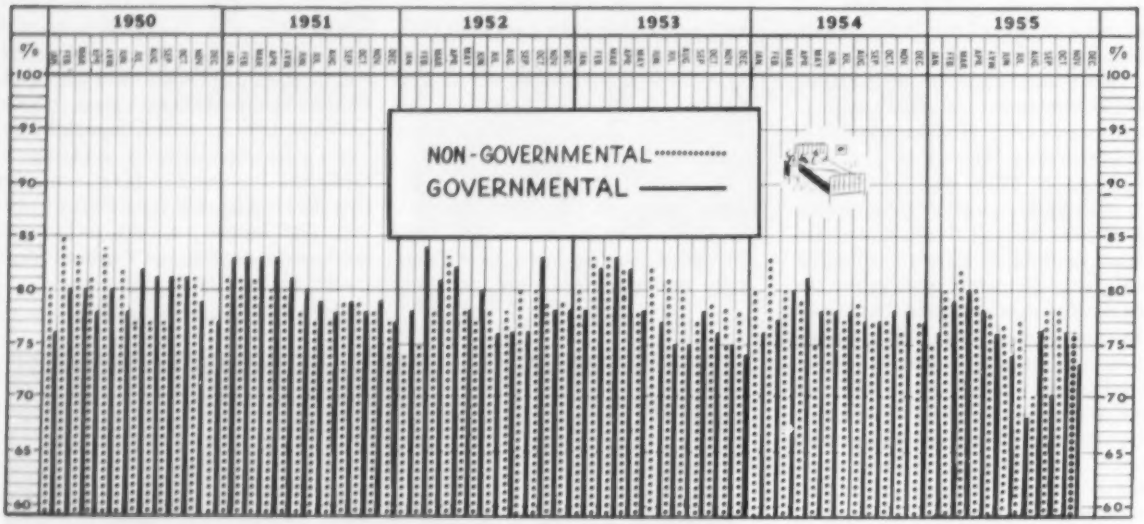
The Rev. B. Reid Wall, administrator of the Methodist Home for Aged, Charlotte, N.C., died October 18.

Dr. Richard L. Harris, manager of the Franklin Delano Roosevelt Hospital of the Veterans Administration, Montrose, N.Y., died November 23, at the age of 59. Dr. Harris had been manager of the hospital since 1950. He was also assistant professor of clinical psychiatry at Cornell University Medical School. He served as a colonel in the army medical corps during World War II. Dr. Harris had been associated with the Veterans Administration since 1921. He was a fellow of the American Medical Association and the American Psychiatric Association and a diplomate of the American Board of Psychology and Neurology.

Sister Alice Regina McCarthy, administrator of St. Elizabeth's Hospital, Elizabeth, N.J., died November 26, at the age of 79. She had been administrator of the hospital since 1937, and a member of the order of Sisters of Charity for 60 years. Prior to her appointment to St. Elizabeth's, Sister Alice Regina was administrator of St. Mary's Hospital, Passaic, N.J. In 1939 she was named a fellow of the American College of Hospital Administrators.

Dr. Henry Wollner, former medical director of St. Joseph's Hospital, Bronx, N.Y., died November 11, at the age of 83. Dr. Wollner had been a member of the hospital staff from 1898 to 1939. In 1915 he was associate professor of diseases of the lungs at Fordham Medical School.

70 Building Projects Cost $75,794,530



In their reports to the Occupancy Chart for the month of November 1955, government hospitals reported occupancy at 73.3 per cent of capacity —down 4.5 per cent from November 1954. Voluntary hospital reports showed occupancy at 75.5 per cent, 0.3 per cent below November 1954.

From November 14 through December 12, hospital construction totaled $75,794,530, bringing the year's total to date to $713,247,679. During the comparable four-week period of 1954, hospital building amounted to $45,204,840, and, at that time, brought the 1954's construction figure to $635,443,478. Of the 70 current projects, 28 are hospitals.

Under Toughest floor traffic and service conditions...

Johns-Manville
TERRAFLEX®
Vinyl-Asbestos Floor Tile

Despite constant exposure to heavy traffic, spilled food, grease and liquids, the Terraflex floor in the cafeteria of the Sperry Gyroscope Company at Lake Success, L. I. shows no sign of wear—looks as fresh and colorful as the day it was installed.

provides beauty, color and wear with minimum care

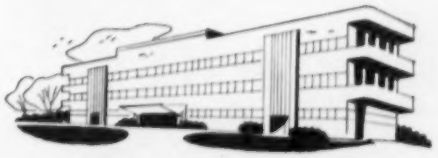
THE Johns-Manville Terraflex tile floor in this busy cafeteria offers daily proof of its ability to meet stringent requirements of heavy-traffic service with lowest possible maintenance cost. In spite of repeated scuffing . . . spilled liquids and foods . . . abusive treatment . . . Terraflex retains its sparkling, new appearance with a minimum of care.

Made of vinyl and asbestos, J-M Terraflex is exceptionally tough and resistant to wear . . . defies grease, oil, strong soaps and mild acids.

Terraflex can reduce maintenance costs one half. In actual use, tests showed Terraflex maintenance expense to be approximately 50% less than the next most economically maintained resilient flooring. Its nonporous surface requires no hard scrubbing . . . damp mopping usually keeps it clean and bright . . . frequent waxing is eliminated. Through years of economical service Terraflex pays for itself.

Available in a range of 15 marbleized colors, J-M Terraflex vinyl-asbestos tile is ideal for restaurants, public areas, schools, hospitals . . . wherever reliable floor service, long-wearing beauty and long-time economy must be combined.

For complete information about Terraflex vinyl-asbestos floor tile, write Johns-Manville Box 158, New York 16, N.Y.



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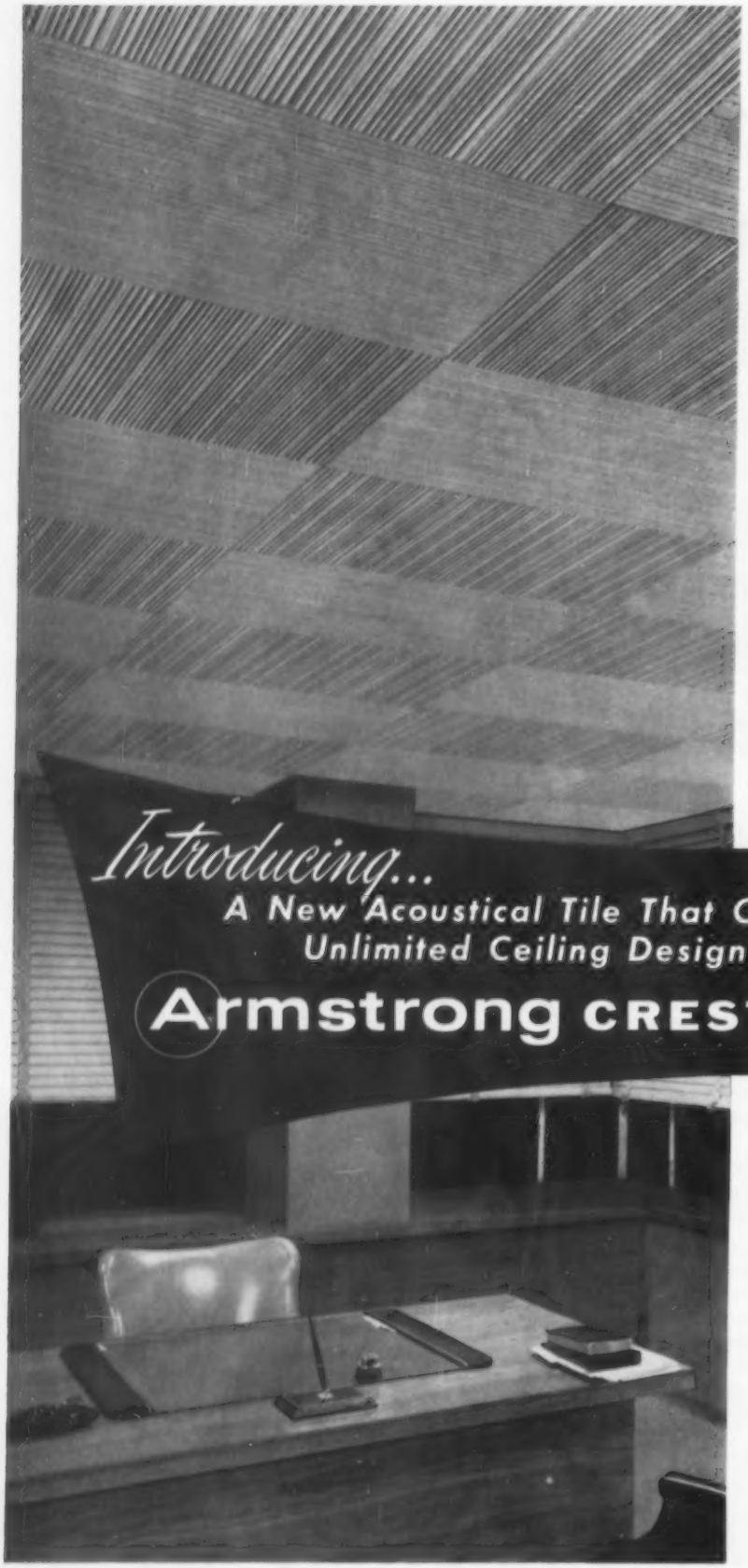

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ADMINISTRATOR—Medical; 5 years teaching medicine; 4 years medical director, large, important university hospital; FACHA.

ADMINISTRATOR—B.S., MPH Johns Hopkins; M.S. Hospital Administration and years' hospital residency, Johns Hopkins 4 years, high school teaching before specializing; 3 years, assistant administrator, 150-bed hospital; 1 year, administrator, 250-bed general hospital, consider any locality, prefers south, west or southwest; excellent references.

ADMINISTRATOR—B.A.; 2 years, administrative assistant; 1 year, assistant administrator, 300-bed hospital; since 1952, assistant administrator, 600-bed general hospital; member, ACHA.

ADMINISTRATOR—R.N.; female, 4 years, administrator, 250-bed hospital; 2 years, director, crippled children's home; consider general or special hospital; south or other localities; excellent references; member, ACHA.

ADMINISTRATOR—Assistant; B.S., Business Administration; M.S. Hospital Administration; Minnesota; years' hospital residency, university hospital; since 1953, assistant administrator, 200-bed medical center; seeks more variety of experience and improved financial status; as assistant; age 27; married; Episcopalian; any locality but prefers upper midwest, northwest; requires $6,500 nominee; ACHA.

ADMINISTRATOR—Assistant; B.S.; M.S.; Hospital Administration February, 1956 upon completion administrative residency, 1,000-bed teaching hospital; prefers St. Louis area, midwest, or north-central; age, 25; married; 2 children; English - Irish; Congregationalist; $6,000.

ANESTHESIOLOGIST—Completing residency; qualified for Boards, May 1956; trained, teaching hospital; 7 years successful private general practice before specializing; southerner.

ANESTHETIST — Woman; registered; early 30's; several years, anesthesia experience; seeks fee-for-service, percentage or similar financial arrangement; southwest.

DIRECTOR OF NURSES — 3 years, college training; considerable staff, supervisory experience; 2 years, director of nurses, smaller general hospital; seeks similar post; southwest.

WOODWARD—*Continued*

EXECUTIVE HOUSEKEEPER—50; 4½ years as executive housekeeper, 250-bed general hospital; similar position desired, does not wish responsibility for laundry; southeast only.

FOOD SERVICE MANAGER—Male; mid-30's; B.S. in Business; 3 years experience, food service manager, hotels and hospitals, southeast, others.

MEDICAL RECORD LIBRARIAN—40's; registered with B.S. degree; outstanding professional experience includes 14 years, chief, general hospital; excellent references; particularly desires opportunity establish new hospital department; southeast.

PATHOLOGIST — 35; Diplomate, pathologic anatomy—clinical pathology; 4 years, associate pathologist, teaching hospital, 600-beds; well qualified in hematology and automic medicine.

PURCHASING AGENT—Woman; 26; single; 4 years, assistant purchasing agent, 150-bed hospital; past year, purchasing agent, 200-bed general hospital; seeks purchasing directorship or administrative assistantship, hospitals not over 300-beds; New England or midwest; $350.

RADIOLOGIST — Certified, diagnostic and therapy; graduate, Tufts; trained important teaching hospital; 2 years, successful private practice, radiology and director, radiology general hospital 100-beds; seeks larger hospital, preferably with some teaching; early 30's; any locality, prefers east.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

PALMOLIVE BUILDING CHICAGO

ADMINISTRATOR—Medical; M.P.H., Hospital Administration; M.S., Health and Physical Education; eight years, assistant superintendent, 1200-bed general hospital; three years, administrative staff, one of leading organizations in graduate medicine.

ADMINISTRATOR — M.H.A.; three years, assistant, teaching hospital; six years, director, 350-bed hospital; FACHA.

ADMINISTRATOR—Professional Nurse; graduate, university hospital school of nursing; B.S., Education; M.S., Hospital Administration; six years' teaching experience before specializing; two years, administrator, 150-bed hospital; references unite in recommending her most enthusiastically.

COMPTROLLER—Eight years, chief accountant and business office manager, university hospital, 800-beds; will consider assistant administratorship.

DIRECTOR OF NURSING; M.A., Education; five years, assistant director of school of service; seven years, director, dual responsibility, 350-bed hospital; led school to national accreditation.

PATHOLOGIST — Diplomate; FACP; eight years, director of pathology, 350-bed general hospital.

(Continued on page 186)

MEDICAL BUREAU—*Continued*

PERSONNEL DIRECTOR—M.A.; six years, personnel director in industry; three years, personnel director, 350-bed hospital.

PURCHASING DIRECTOR; B.S., state university; 11 years, purchasing director, large teaching hospital.

RADIOLOGIST—Diplomate, diagnosis, therapy, radium; three-year residency, teaching center; four years, associate radiologist, 700-bed hospital; wishes own department.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director

332 Bulkley Building

Cleveland, Ohio

ADMINISTRATOR—F.A.C.H.A.; 20 years experience, in two eastern hospitals; excellent record.

ADMINISTRATOR—M. S., M.H.A. Degrees, University of California. 4 years credit and business manager, large mid-western hospital; at present administrator, 100-bed hospital.

ASSISTANT ADMINISTRATOR—M.H.A. Degree; previous experience as pharmacist; 2 years assistant administrator, teaching hospital, Pennsylvania.

BUSINESS MANAGER—Or comptroller; 300-400 bed mid-western hospital, preferred; B.S. Degree in Business Administration; 6 years experience.

ADMINISTRATOR—R.N.; successful experience in three hospitals, New York, Ohio and Michigan, 50-85 beds; familiar with building program activities.

PHARMACIST—Chief; B.S. Degree, 1951; 2 years pharmacy internship; 2 years experience, 1,000-bed hospital.

EXECUTIVE HOUSEKEEPER—2 years' college; 2 years' training, hotel housekeeping; past 6 years, head housekeeper, 250-bed California hospital.

MEDICAL PLACEMENT SERVICE

Mrs. Stewart R. Roberts, Director

15 Peachtree Place, N. W.

Atlanta, Georgia

ADMINISTRATOR—Male; 25, married, B.S.A. with background of premedical, laboratory and x-ray training and experience, available immediately.

ADMINISTRATOR—Male; 25, single, B.B.A., experienced in administrative responsibilities.

ADMINISTRATOR—Male; 49, married, retired from Naval service; twenty years' experience in hospitals ranging from 50 to 3000 beds.

ADMINISTRATOR—Male; thoroughly trained and experienced, particularly in organizing medical groups; salary required $12,000.

ASSISTANT ADMINISTRATOR—Male; 22, single, on-the-job training in all phases hospital administration and management.

classified advertising

POSITIONS WANTED

MEDICAL PLACEMENT—*Continued*

PURCHASING AGENT—Male; 36, married, 7 years varied experience in supplies.

PERSONNEL ADMINISTRATOR—Male; 32, married, A.B. in Sociology, M.B.A. in Industrial Relations; 5 years' experience as personnel assistant.

BUSINESS MANAGER—Male, 35, certified business administration, prefers clinic.

POSITIONS OPEN

ADMINISTRATORS—Nursing Service and Education—Opportunities throughout the country in all types of hospitals, schools of nursing, public health agencies. Many openings for INSTRUCTORS in all specialties. No fee. Apply in person or write to Nurse and Medical Placement Center, New York State Employment Service, 136 East 57th Street, New York 22, New York.

ANESTHETIST—Registered; experienced; salary open, 40-hour week, 8 hour day; 200-bed general hospital. Apply P. O. Box 840, Battle Creek, Michigan.

ANESTHETISTS—2 nurse anesthetists to increase staff; approved A.A.N.A. training school; good working conditions; medical anesthesiologist in charge of department. Apply Director, Department of Anesthesiology, Lancaster General Hospital, Lancaster, Pennsylvania.

ANESTHETIST—Registered nurse; 5 year old 100-bed hospital; air-conditioned operating and delivery rooms; $500.00; active surgical service; two anesthetists give about 2,000 anesthesias annually; 10,000 population; Reply direct to Obion County General Hospital, Union City, Tennessee.

ANESTHETIST — Nurse; female; excellent starting salary; merit increases; liberal fringe benefits; good hours; accredited hospital and surgeons limited to our staff. Apply to Elmer J. Berg, Business Manager, Gunderson Clinic, La Crosse, Wisconsin.

ANESTHETIST-NURSE; 60-bed general hospital, new building, modern equipment, western Wisconsin, college town; vacation, sick leave, retirement plan. Apply to H. C. Guntner, Manager, Memorial Hospital, Menomonie, Wisconsin.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 N. Maryland Avenue, Milwaukee 11, Wisconsin.

ASSISTANT DIRECTOR, NURSING SERVICE—Responsible for nursing service in 400-bed non-profit hospital which includes 115-bed pediatric unit; friendly city 225,000; prefer candidate with successful experience and preparation in nursing service administration; 40-hour week; salary open; position available January 1, 1956. Apply Director of Nursing Service, Iowa Methodist Hospital, Des Moines, Iowa.

ASSISTANT MEDICAL DIRECTOR—100-bed tuberculosis hospital, North American graduate, salary $8500, complete maintenance. Apply Medical Director and Superintendent, District Five Tuberculosis Hospital, London, Kentucky, or State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

DIETITIAN—Administrative; 242-bed general hospital, with assistant dietitian and school of nurses; salary open. Apply MO 121, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—For therapeutic and administrative duties in suburban hospital 16 miles west of Chicago's loop; desirable personnel policies and starting salary. Please write F. L. Unzicker, Administrator, Memorial Hospital, Elmhurst, Illinois.

DIETITIAN—Chief; A.D.A. member, 160-bed general hospital fully approved; good personnel policies; salary open. Apply Frederick Memorial Hospital, Frederick, Maryland.

DIETITIAN—Registered chief; 110-bed general hospital; duties involve therapeutic diet planning, patient contact, general supervising; salary open. Contact M. I. Clement, Saratoga General Hospital, 15000 Gratiot Avenue, Detroit 5, Michigan.

DIETITIAN—For 60-bed general hospital; to be in full charge of kitchen and food service; desirable personnel policies and starting salary; located in a resort city on the shores of Lake Michigan. Write Ralph W. Tarr, Administrator, Municipal Hospital, Grand Haven, Michigan.

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Full charge ADA for 135-bed hospital fully approved. Apply The Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIAN—Assistant to chief; 160-bed general hospital; college town of 25,000, 20 miles west of Milwaukee; modern dietary department completely remodeled in 1955. Write Robert M. Jones, Administrator, Waukesha Memorial Hospital, Waukesha, Wisconsin.

DIRECTOR — Medical social service; 290-bed general hospital; east; expansion program; fully accredited; salary open; generous personnel policies. Apply MO 122, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING SERVICE—Top opportunity progressive 300-bed general hospital, planning new 450-bed facility; Degree, administrative line experience and high supervisory ability necessary; salary commensurate with capabilities; fine potential; position available now. Contact Edgar O. Mansfield, Superintendent, White Cross Hospital, Columbus 8, Ohio.

HOUSEKEEPER — Executive; to supervise housekeeping department in new 110-bed hospital now undergoing expansion; high standards of sanitation; excellent administrative cooperation; some supervisory experience in institutional housekeeping or related fields is required; to age 40; one month's vacation plus other liberal benefits. Apply Personnel Director, Weiss Memorial Hospital, 4646 Marine Drive, Chicago 40, Illinois.

INSTRUCTOR—Medical Surgical; to share with other instructor responsibility for medical surgical nursing correlated course; school has 105 students, NLN temporary accreditation; 242-bed hospital with 85 bassinets; B.S. degree required. Apply to Personnel Director, Methodist Hospital, 1600 W. 6th Avenue, Gary, Indiana.

(Continued on page 188)

INSTRUCTORS—Clinical; two, for medical and surgical wards; salary open; B.S. minimum requirement, experience necessary; liberal personnel policies. Apply Director of Nursing, Wheeling Hospital, Wheeling, West Virginia.

INSTRUCTOR—Medical and surgical nursing; 200-bed general hospital, school 75 students, B.S. degree in nursing or nursing education, experience in teaching; excellent salary; liberal personnel policies. Apply Director of Nursing Education, Good Samaritan Hospital, Vincennes, Indiana.

LIBRARIAN — Medical record — registered; to assume charge of record room; 110-bed general hospital; salary open. Contact M. I. Clement, Saratoga General Hospital, 15000 Gratiot Avenue, Detroit 5, Michigan.

LIBRARIAN—Registered medical record; for 212-bed general teaching hospital. Contact Assistant Administrator, Mt. Sinai Hospital, Minneapolis 4, Minnesota.

LIBRARIAN—Medical record; registered; to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

LIBRARIAN—Medical records; registered or eligible for registration, to assume charge of records room; new general hospital of 150-beds and 30 bassinets; salary open; Apply giving outline of education and experience to: Executive Director, Miriam Hospital, 164 Summit Avenue, Providence 6, Rhode Island.

LIBRARIAN—Medical record; for 250-bed modern general hospital with extension plan. Apply Administrator, St. Mary's Hospital, Montreal, Quebec, Canada.

MEDICAL DIRECTOR—North American graduate; five years tuberculosis experience, relatively new 100-bed tuberculosis hospital; salary $10,000, complete maintenance. Apply State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

NURSES—Consider this; a modern 150-bed hospital in a modern city of 20,000 with unexcelled community activity opportunities; starting staff nurse salary $273.00 with five merit increases; advancement opportunities; inquiries welcomed. Write for descriptive information to Director of Nurses, Midland Hospital, Midland, Michigan.

NURSES—Graduate; two; if interested contact Medical Director, Florida State Hospital, Arcadia, Florida.

NURSES—Head surgical and staff; for 50-bed new hospital, latest equipment; positions open now; attractive salary, living expenses reasonable. Apply St. Joseph's Hospital, Del Norte, Colorado.

NURSES—Head and graduate staff; for modern 300-bed expanding general hospital located in an attractive cultural city with educational advantages; all shifts, 44 hour week, excellent living quarters, periodic increases and opportunity for promotion, salary commensurate with qualifications and experience, paid vacations, sick leave, and holidays. Apply Director of Nursing Service, Memorial Hospital, 1501 Van Buren Street, Wilmington, Delaware.

NURSES—Operating room and obstetrics; California hospital on San Francisco Bay, 40 minutes from that city, 5-day week, salary $305 per month if applicant has advanced preparation or experience, $10 additional for evening and night duty, maintenance available. Apply Director of Nursing, Alameda Hospital, Alameda, Calif.

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POSITIONS OPEN

NURSES—Operating room; 200-bed hospital, 40 hour week; all cash salary-bonus for on call; special consideration for experience and advanced preparation; social security and retirement plan. Apply Director of Nursing, Mercer Hospital, Trenton 8, New Jersey.

NURSES — Operating room; immediate appointments; 511-bed newly enlarged and finely equipped hospital; ten operating rooms now completed; northeastern Ohio stable "All American City" of 120,000; in center of area of recreational, industrial and educational friendly activities; living cost reasonable; within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania; friendly and considerate working associates and conditions; progressively advanced personnel policies; starting salary $240.00 per month with four merit increases; paid vacation, sick leave, recognized, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

NURSES—Operating staff; good personnel policies for Buffalo General Hospital. Apply Mrs. Aileen L. Carroll, Director of Nursing.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSE — Registered; for 50-bed tuberculosis hospital in Indiana college town; salary $325.00 per month. Excellent working conditions; liberal vacation and sick leave. Address appitcations to Superintendent Smith-Esteb Hospital, Richmond, Indiana.

NURSES—Registered; Massachusetts General Hospital, Boston, Massachusetts; excellent clinical facilities, opportunity for advancement and attendance at local colleges; liberal personnel policies. Apply Personnel Department A-10 for further details.

NURSES—Registered staff; age 21-45; three year graduates preferred; 45-bed general hospital; partly segregated services; congenial medical staff; rotating shifts; $252.50 a month base pay; $15.00 differential for evenings and nights; eight paid holidays; fourteen days paid vacation, twenty-one days after three years; retirement plan; other liberal personnel policies; beautiful nurses home with television; $20.00 monthly full maintenance; town of 9,000, surrounded by mountains; desirable climate year round. Apply Director of Nurses, Miners' Hospital of New Mexico, Raton, New Mexico.

NURSES—Registered; for medicine, surgery, orthopedics and urological services; 200-bed hospital in upstate medical center; tuition benefits at Syracuse University; 40-hour week; New York State registration required; starting salary according to experience. Write Director of Nursing, Good Shepherd Hospital, 150 Marshall St., Syracuse 10, New York.

NURSES—Registered staff; immediate appointments; 511-bed newly enlarged and finely equipped general hospital; duty assignments in medical, surgical, pediatrics, psychiatric, obstretics, or contagion units; northeastern Ohio stable "All American City" of 120,000; in center of area of recreational, industrial, and educational friendly activities; living costs reasonable; within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania; friendly, cooperate work relations and conditions; progressively advanced personnel policies. Starting salary $240.00 per month with four merit increases; paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

NURSES—Registered; for new 40-bed hospital located in Texas vacation land, near large cities; all shifts; excellent salary and personnel policies. Write Administrator, New Braunfels Hospital, Inc., New Braunfels, Texas.

NURSES—Registered; for operating room and general floor duty. Two general floor supervisors—one for 3-11 and one for 11-7. Apply, Martinsville General Hospital, Martinsville, Virginia.

NURSING MISCELLANEOUS—Operating Room Nurses; Instructor, Assistant Supervisors, Scrub Nurses; salary and personnel policies comparable to other hospitals in this area. Write Director of Nursing, Box P, St. Luke's Hospital, New York 25, New York.

PHARMACIST—150-bed modern hospital in Ottumwa, Iowa; start $400.00; pharmacy air-conditioned. Apply MO 119, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

PHYSICAL THERAPIST — Woman; experienced in rehabilitation work; registered; good recommendations; five day week, 200-bed general hospital. Write P. O. Box 840, Battle Creek, Michigan.

RADIOLOGIST—Full-time associate; certified; 486-bed general hospital; very active department and fully equipped for x-ray work; opportunity for qualified radiologist, excellent remuneration; state training, experience, availability, marital status, etc. Apply Director, The Royal Columbian Hospital, New Westminster, British Columbia, Canada.

SECRETARY—Medical; speedy typist; experienced with medical terminology and use of ediphone machine; excellent salary; 5 day week, 8 hour day; 200-bed general hospital. Write P. O. Box 840, Battle Creek, Michigan.

SUPERINTENDENT OF NURSES—General non-profit hospital; 301-beds; approved school of nursing, 70 students; salary open. For details write Superintendent, Norfolk General Hospital, Norfolk, Virginia.

SUPERVISOR—Central sterile supply; should be well-grounded in modern techniques; new hospitals opening in Kentucky, Virginia and West Virginia in early fall; good personnel policies, 40 hour week, 4 weeks paid vacation, a non-contributory retirement plan; salary range $370-$445. Apply to Mr. Philip J. Olin, Miners Memorial Hospital Association, 1427 Eye Street, N.W., Washington 5, D.C.

SUPERVISOR—Obstetric instructor; obstetric experience required; degree desired; 300-bed general hospital, maternity department averaging 1500-1800 deliveries; salary and maintenance open. Apply Director School of Nursing, Washington County Hospital, Hagerstown, Maryland.

SUPERVISOR—Obstetrics; post graduate work in obstetrics and supervisory experience required; immediate opening; modern and up-to-date department; social security and excellent personnel benefits. Apply Director of Personnel, White Cross Hospital, 700 North Park Street, Columbus 8, Ohio.

SUPERVISOR—Operating room; for 200-bed general hospital; located in scenic Virginia; new 6 room suite; good personnel policies; salary commensurate with preparation and experience. Apply Louise M. Reynolds, Superintendent, C. & O. Hospital, Clifton Forge, Virginia.

SUPERVISOR—Operating room; 250-bed general hospital; advanced preparation necessary; capable of assuming teaching responsibility; optional 44 or 40 hour week, salary open. Apply Northwest Texas Hospital, Amarillo, Texas.

TECHNOLOGIST—Medical; preferably M.T. (A.S.C.P.) for 200-bed hospital in college town; rotating service; new laboratory; good personnel policies. Apply Middlesex Memorial Hospital Laboratory, Middletown, Connecticut.

TECHNICIANS—Laboratory; openings exist in modern laboratory; good salary and working conditions. For further details apply to Mr. C. V. Wynne, Administrator, Waterbury Hospital, Waterbury, Connecticut.

TECHNICIAN—Laboratory; for general hospital work in small institution; knowledge of X-ray technique preferable but not required; ideal location for ski enthusiast. Apply Administrator, The Memorial Hospital, North Conway, New Hampshire.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS—(a) Medical director; 350-bed general hospital; staff includes business manager; California; $15,000. (b) Medical consultants; 40%-5% travel. (c) Administrator; 275-bed general hospital opened for operation December '53; building program soon to be completed will increase to 400; coastal and resort city, south; degree and successful experience as administrator required. (d) Voluntary general hospital, 150-beds; building program will increase to 250; large city, medical center, east. (e) General 250-bed hospital affiliated university operated under American auspices, foreign city; duties include conducting program for hospital administrators. (f) Assistant administrator; voluntary general hospital, 400-beds; qualified to assume heavy responsibilities; university city, midwest. (g) Assistant medical director; 350-bed teaching hospital; west. (h) Clinic manager; 12-man group; midwest. MH1-1

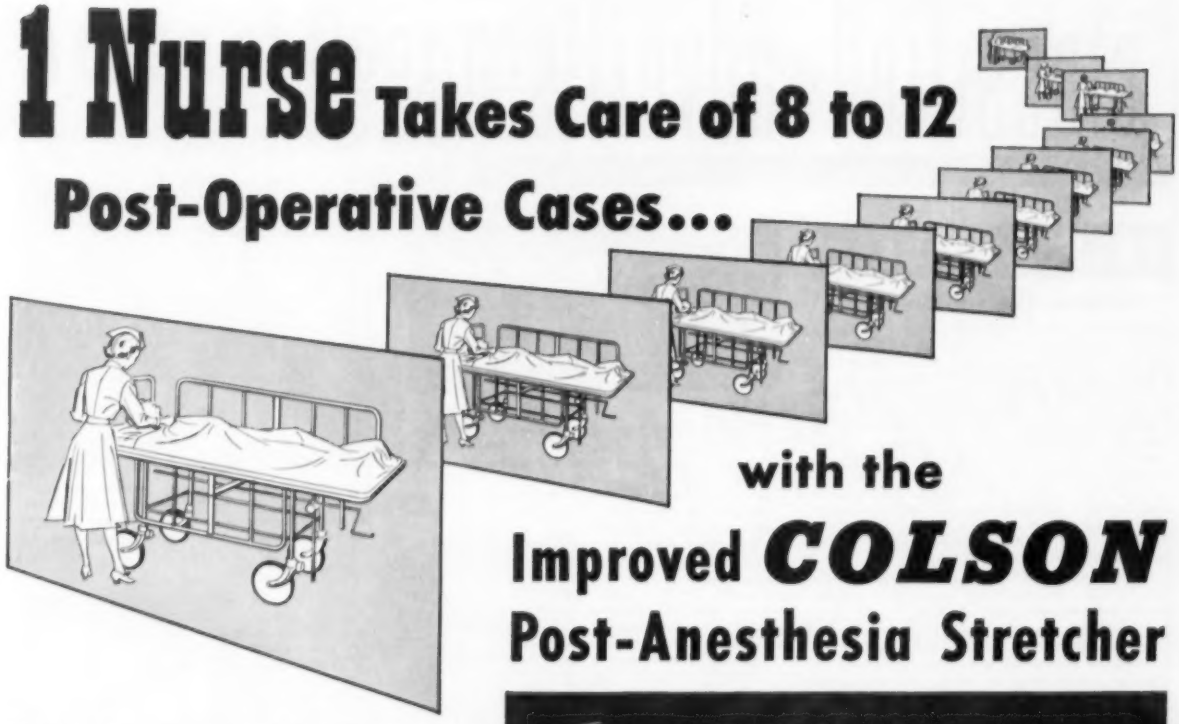
ADMINISTRATORS—Women. (a) Small, modern hospital; year-round resort area; $6000-$7000. (b) Small hospital; tropical city, Caribbean region; transportation, maintenance provided. MH1-2

ANESTHETISTS—(a) To join fine staff of four anesthetists; foreign operations; new 250-bed American owned hospital, modern, air-conditioned; $10,000. (b) Two staff; 250-bed general hospital; department headed by medical anesthesiologist; $6000; Florida. (c) New 125-bed general hospital; month's vacation yearly; $6500; southeast. (d) Small general hospital; attractive college town, near San Francisco; $5000-$6000. MH1-3

DIETITIANS—(a) Chief; reorganize department; 560-bed hospital; supervise eight dietitians and staff of 115; decentralized service; near New York City. (b) Administrative; charge of department; fully staffed, modern equipment; 110-bed hospital; south; $5400. (c) Chief; hospital group, 800-beds, affiliated medical school; faculty rank; outstanding opportunity; $8000. MH1-4

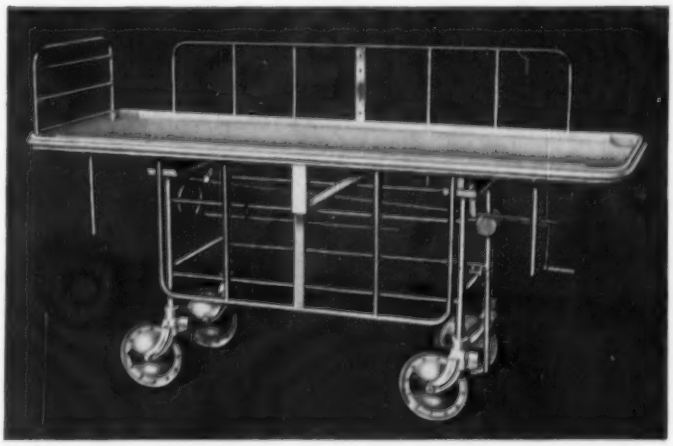
(Continued on page 190)

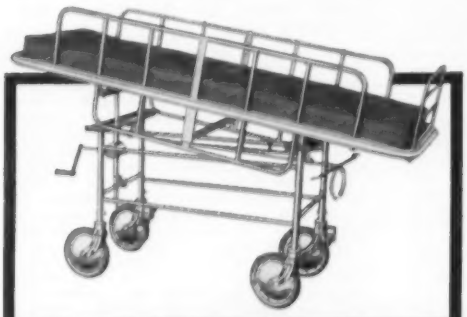
1 Nurse Takes Care of 8 to 12 Post-Operative Cases...



with the Improved COLSON Post-Anesthesia Stretcher

More and more progressive hospitals are adopting the modern procedure of post anesthesia recovery rooms. Here patients are under the supervision of experts in post-operative care—with blood pressure units, gas tank and suction pump at hand in case of emergency.





Colson model No. 6878 Post-Anesthesia Stretcher with litter raised to shock position. Elevating unit automatically locks in any position up to 20" elevation.

Now, with the COLSON post-anesthesia stretcher, one nurse can take care of 8 to 12 post-operative patients—a substantial savings in time, money and skilled help.

The new model No. 6878 stretcher shown here is the latest thing in post-operative care. Made of sturdy arc-welded tubular construction it is equipped with every device for the patient's comfort and safety, including easy-rolling, positive-locking casters with conductive rubber tires.

Write today for free descriptive literature

WHEEL CHAIRS • WHEEL STRETCHERS • INHALATORS
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Elyria, Ohio

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

DIRECTORS OF NURSING—(a) Associate director, nursing service; new 300-bed air-conditioned hospital operated under American auspices, foreign country; $12,000. (b) Director, school and service; pediatric hospital; university city, east; minimum, $6000. (c) General 400-bed hospital currently under construction; completion late 1956; preferably one available soon in order to organize departments; no school during first year of operation; university city, south. (d) Director of nursing and school; 200-bed hospital affiliated university; American auspices; Near East. (e) Director, new 70-bed hospital; noted resort area; southwest; $6000. MH1-5

EXECUTIVE HOUSEKEEPER—General 400-bed hospital; university affiliation; four million dollar building program. MH1-6

EXECUTIVE PERSONNEL—(a) Purchasing director; 900-bed general hospital; degree, comprehensive experience required; experience industrial engineering or business management advantageous; midwest. (b) Comptroller; 800-bed general hospital; supervisory experience in hospital accounting field required; east. (c) Public relations officer; 500-bed teaching hospital; university city; south. (d) Business manager; 250-bed hospital; 350 employees; department head status; university and resort city, southwest. (e) Food supervisor; new position; 400-bed teaching hospital; key city, east. (f) Chief engineer qualified; serve as administrative assistant in charge of maintenance; 700-bed general hospital; expansion program; east. MH1-7

FACULTY POSTS—(a) Pediatric, operating room, obstetrics clinical instructors; new university department of nursing; $5400. (b) Assistant professor, fundamentals of nursing, medical, surgical nursing; 150 students; co-educational university of 3000; west. (c) Operating room, obstetrics, pediatric instructors; Latin America; attractive salaries; transportation provided. (d) Nursing arts, medical, surgical, clinical instructors; 300-bed general hospital; 100 students; ideal California location; $4500. (e) Educational director; hospital operated by American company in foreign country; 40 students; school to be increased to 60-70; $660-$865, maintenance. MH1-8

RECORD LIBRARIANS—(a) Chief; 650-bed hospital; new progressive medical center; college town, south; $5000. (b) Chief; top flight; outstanding clinic; with research facilities; noted health resort; southwest. (c) Assistant; responsible position; large teaching hospital; very active out-patient department; greater New York; $4700. MH1-9

STAFF, SCRUB—(a) Staff, scrub; large general hospital; $290 - $315 respectively; metropolitan area, Southern California; transportation refunded. (b) Scrub and obstetric nurse; small general hospital; tropical island; $425. MH1-10

SUPERVISORS—(a) Obstetrics, communicable disease, medical, surgical; 300-bed air-conditioned hospital, American owned; foreign location; $8500-$9200. (b) Central supply; brand new 200-bed hospital; college town, southeast; $375. (c) Obstetrics; 350-bed general hospital; Lake Michigan suburb; $375. (d) Surgical; progressive department; modern facilities; 200-bed general hospital; south; $5340. (e) Afternoon; responsible position; attractive new 200-bed hospital; wealthy Chicago suburb; $375. (f) Operating room; direct 14 nurses in 7 room suite; 600 operations monthly; San Francisco Bay area; $4500. (g) Floor or specialties, interested in becoming directors, nursing service; 50-100 bed hospitals; metropolitan and rural areas; $4500-$5000, frequently maintenance included. MH1-11

(Continued on page 192)

WOODWARD—*Continued*

ANESTHETISTS—(a) Several; 10 outstanding new hospitals; $6400; excellent personnel policies; recommended. (b) New department now being established; will be under supervision of M.D.; outstanding clinic group, affiliated 125-bed general hospital; $7200; large university city; midwest. (c) As staff anesthetist, or free lance basis for two hospitals; Texas community of 15,000.

DIETITIANS—(a) Chief; 300-bed general hospital expanding to 500 within one year; all new dietary facilities to be included; minimum $4800; large university city; midwest. (b) Voluntary general hospital 75-beds; approved; $350, full maintenance; lovely small Pacific Northwest community. (c) Assistant or therapeutic; excellent departmental facilities; approved 300-bed general hospital; community 50,000; east.

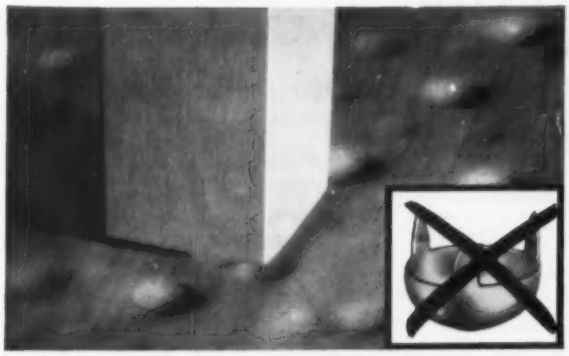
DIRECTOR OF NURSES—(a) Organize and establish nursing service and training school; new 400-bed hospital scheduled for completion fall 1956; will employ some months in advance; to $7200; lovely southern city. (b) Nursing service and education; qualified assistants in both; voluntary general hospital 300-beds, medical school affiliated; 70 students; to $7000; city 100,000; east. (c) Nursing service only; in-service training; general hospital 200-beds; to $6000; capital city; northwest. (d) Nursing service; some educational duties; 600-bed long term hospital; minimum $6600; large university city; midwest.

EXECUTIVE HOUSEKEEPERS—(a) Also supervise 4 nurses' homes and educational building in addition to 7-story, 200-bed general hospital; medical school affiliated; excellent eastern university center. (b) Voluntary general hospital 250-beds; affiliated important medical school; Pacific Northwest. (c) 400-bed general hospital; university affiliated; large southeastern city.

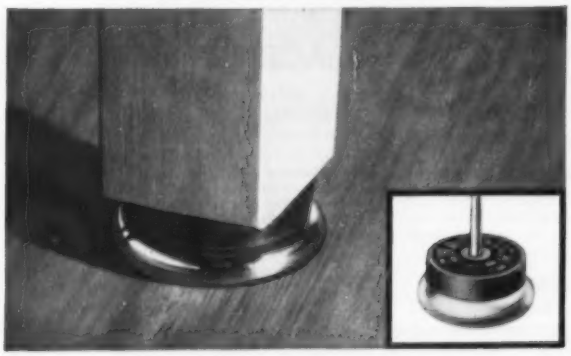
FACULTY POSTS—(a) Director, practical nurse education, accredited junior college; full responsibility under Dean for establishing new program to $7100 or better, depending on academic preparation; residential suburb, university city; east. (b) Educational director; school has temporary national accreditation; fully approved voluntary general hospital; 300-beds; lovely college community; midwest. (c) Medical and surgical instructors; collegiate school; 250 students; south. (d) Psychiatric instructor; large hospital; diploma program; affiliated with 2 universities; large city; south.

SUPERVISORS—(a) Operating room; general hospital 600-beds; to $5300; east. (b) Pediatric; approved 250-bed general hospital; training school; lovely town 20,000; southeast. (c) Operating room; approved voluntary general hospital 100-beds; prefer with postgraduate training; $4800; attractive county seat town 15,000; Pacific Northwest.

A case of floor pox!



Its cause



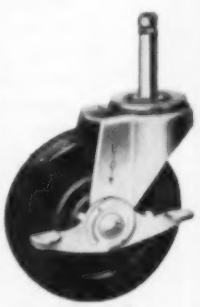
...and remedy

When floors break out in a rash of pock marks, the cure is usually expensive. You either repair or replace!

Stop floor pox before it starts by equipping chairs and tables with Bassick's Rubber-Cushion Glides. Their broad, flat, hardened-steel base distributes furniture weight evenly over a large area. They slide at a touch without leaving unsightly trails. You can adapt them to either wood or metal furniture.

QUIET, PLEASE!

There's no quieter or easier way to move hospital beds, tables, screens and service carts than on Bassick's "Diamond-Arrow" casters. Whisper-quiet in action, they roll at a touch and swivel easily. Soft rubber treads will not put a pox on floors. Send for copy of Catalog HPF-54 today. THE BASSICK COMPANY, Bridgeport 2, Conn. *In Canada*: Belleville, Ont.



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WITH WHITE SILENT MOPPING EQUIPMENT

SILENT OVAL BUCKET

White Silent Cleaning Equipment is especially made for use in hospitals and institutions where quietness is essential. The Silent Oval Bucket illustrated is fully insulated against noise by use of rubber at all points of metal to metal contacts.

SILENT ROL'OVL

The famous White Rol'Ovl Mop Wringer is insulated throughout against noise in operation. Equipped with rubber rollers.

SILENT MOPMASTER

The most efficient Double Mopping Outfit made with the added features of silent operation. Two Silent Oval Buckets — one for cleaning solution and one for rinse water and the "Can't Splash" Squeezer combined with a sturdy rubber protected steel truck that moves quietly and easily.

Send for Catalog No. 153

WHITEY MOPZUM SAYS: *It's RIGHT . . if it's*

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Canadian Factory, Paris, Ontario Can.

WHITE

A COMPLETE LINE OF FLOOR CLEANING EQUIPMENT

classified advertising

POSITIONS OPEN

SHAY—*Continued*

DIETITIANS—(a) Chief; east; 30 in department; 2 very capable assistants; $4800. (b) Chief; east; 350-bed hospital; 60 in department; $5400. (c) Chief; south; 300-bed hospital; A.D.A.; $6000. (d) Chief; California; 235-bed hospital near San Francisco; $5000. (e) Therapeutic; middle west; 200-bed hospital; $4500. (f) Therapeutic; east; 350-bed hospital; $4200. (g) Chief; east; 115-bed hospital; some teaching; $5400.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATORS—(a) 95-bed hospital, New York State. (b) 150-bed hospital, school of nursing; suburb, industrial city, east; new 100-bed addition planned. (c) 55-bed hospital, Ohio. (d) Assistant, 125-bed hospitals, Pennsylvania, Ohio, Michigan.

BUSINESS MANAGERS—(a) 150-bed hospital, vicinity of Baltimore. (b) 475-bed hospital, east. (c) 225-bed hospital, southwest; open January. (d) 150-bed Ohio hospital; large outpatient clinic; salary $7000.

INTERSTATE—*Continued*

DIRECTORS, NURSING SERVICE—(a) 155-bed southern hospital; affiliate student nurses. (b) 200-bed hospital, Indiana. (c) New 200-bed hospital, Ohio.

DIRECTORS, SCHOOL OF NURSING—(b) Instructors of nursing; to $500; attractive location. (c) Supervisor, central supply; new hospital; salary $400.

EXECUTIVE HOUSEKEEPERS—(a) 300-bed hospital, Pennsylvania. (b) 170-bed hospital, New York. (c) 225-bed teaching hospital, new building; $400; midwest.

RECORD LIBRARIANS—(a) 175-bed hospital, midwest; $450. (b) 300-bed eastern hospital; $400.

TECHNICIANS—(a) Laboratory; $350. (b) X-ray; to $350. (c) Pharmacists; to $500.

MEDICAL PLACEMENT SERVICE

Mrs. Stewart R. Roberts, Director
15 Peachtree Place, N. W.
Atlanta, Georgia

THERAPEUTIC DIETITIANS — ADA: (a) Texas hospital, 3 weeks vacation, $325. (b) Miami Beach, $300, age to 40. (c) Tidewater Virginia, $350.

MEDICAL PLACEMENT—*Continued*

BACTERIOLOGIST — Texas; female, $375 monthly.

LABORATORY TECHNICIANS—(a) Mobile Bay, $400; (b) Georgia, chief technician, ASCP, $400. (c) Kentucky, 3-week vacation; ASCP; $350.

ANESTHETISTS — Nurse: (a) Mississippi, $350 plus room, board, and laundry. (b) South Carolina, $425 plus maintenance, urgent.

NURSE—Supervisors: (a) Kentucky, $325; apartment. (b) Mississippi Gulf Coast, $300 plus maintenance. (c) Florida, $500, critical need.

NURSE—General duty; openings throughout the country; Alabama coast, Georgia coast and mountains, Florida, Kentucky.

PLACEMENT BUREAUS

INDIANA MEDICAL BUREAU
212 Bankers Trust Bldg.
Indianapolis, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

(Continued on page 193)

classified advertising

PLACEMENT BUREAUS

MARY A. JOHNSON ASSOCIATES

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Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

Agency

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Baltimore 2, Maryland

"LExington 9-5029"

Chas. J. Cotter, Director

(Former Administrator)

Nation-wide placement service for Physicians, Administrators, Anesthetists, Dietitians, Nurses, Technicians, Pharmacists, Comptrollers, Accountants, Secretary, Housekeepers, etc.

Mail resume, 5 photos, salary.

No Registration Fee. Licensed Employment Agent.

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ZINSER PERSONNEL SERVICE

Anne V. Zinser, Director

Suite 1004—79 West Monroe Street

Chicago 3, Illinois

We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

(Continued on page 194)

FOR SALE

NURSING AND MEDICAL BOOKS

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

CUBICLE CURTAINS

Grommet or slider type. Your choice of colors and materials including jeans, twills, topsail and duck. Send list of sizes and particulars. I will furnish firm quotation and samples.

William A. McDonough

11 Glenwolde, Tarrytown, N. Y.

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5 Number 15 Units GRAND RAPIDS SCHWARTZ SECTIONAL CABINETS. Each Unit consists of three tiers of 5 drawers to a tier, for a total of 75 drawers. Each Unit is 45¼" high, 1'6" deep, and 2'0" long. White enamel finish. $600.00. F.O.B. Altoona. Inquire: The Altoona Hospital, Altoona, Pa.

classified advertising

FOR SALE

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS

400 East 59th Street, New York City

BRAND NEW SCANLON-MORRIS 16x24 stainless steel, double jacketed, electric autoclaves, 110/220 V, AC, complete with STERO-MASTER automatic sterilizing control, $1000.00, f.o.b. Boston.

MEDICAL SALVAGE CO., INC., 217 East 23rd St., New York 10, N.Y. Murray Hill 4-4267.

MISCELLANEOUS

ADVERTISEMENT FOR BIDS

The City of Luverne, Rock County, Minnesota, will receive sealed bids for X-ray Equipment and Installation until 1:30 o'clock P.M. on the 10th day of January, 1956, at the office of the City Recorder in the City Hall, Luverne, Minnesota, at which time and place all bids will be publicly opened and read.

Proposal must be on proposal forms provided for the purpose and submitted in a sealed envelope addressed to the City of Luverne. Proposal must be submitted to the City Recorder on or before the above stated time. Proposal is for the furnishing of all labor, equipment, materials, and performing all work for a complete installation. Proposal forms, including specifications are on file at the office of the City Recorder, Luverne, Minnesota, and may be obtained by making a deposit of $5.00, refunded upon receipt of a bona fide bid or return of the specifications.

All bids must be accompanied by a cash deposit or certified check, payable to the City of Luverne, Minnesota, in an amount equal to at least five percent (5%) of the total bid.

(Continued on page 195)

No bidder may withdraw his bid for at least thirty days (30) days after the scheduled closing time for the receipt of bids, without the consent of the City of Luverne, Minnesota.

The City of Luverne reserves the right to reject any or all bids and waive any informalities in bidding.

By order of The Common Council, City of Luverne, Minnesota.

Dated: December 6, 1955.

Fred Mitchell, Recorder.

SCHOOLS—SPECIAL INSTRUCTION

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

classified advertising

SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

TOO LATE TO CLASSIFY

POSITIONS WANTED

ADMINISTRATOR OR ASSISTANT ADMINISTRATOR — Over 20 years experience; university graduate; namely business administration and engineering; relocate most anywhere; consider small hospital. Address MW 97, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

POSITIONS OPEN

ANESTHETIST—Nurse: JCAH approved 330-bed hospital in Detroit area; $425 per month starting, overtime after 40 hours, paid holidays, excellent fringe benefits, longevity pay; paid on-call time; surgical and obstetrics-gynecology residencies. Apply Highland Park General Hospital, Highland Park 3, Michigan.

DIETITIAN—Teaching; experienced, member of A.D.A. for school of nursing; good personnel policies. Write to Mrs. Aileen L. Carroll, Director of Nursing, The Buffalo General Hospital, Buffalo, New York.

DIRECTOR OF NURSING SERVICE—New voluntary general hospital of 150-beds and 30 bassinets; salary open, living out. Apply giving outline of education and experience to Executive Director, Miriam Hospital, 164 Summit Avenue, Providence, Rhode Island.

DIRECTOR OF NURSING SERVICE—ASSISTANT; 8 hour day, 40 hour week; liberal personnel policies; salary as recommended by the district with semi-annual increments. Write to Director of Nurses, William McKinley Memorial Hospital, Trenton, New Jersey.

INSTRUCTOR—Nursing; for 184-bed general hospital; degree and experience necessary; salary commensurate with preparation; liberal personnel policies, 5-day, 40-hour week, 8 paid holidays, vacation and sick leave, group insurance and social security; salary increment of $5 twice a year. Apply Director of Nurses, William McKinley Memorial Hospital, Trenton, New Jersey.

NURSES—Staff; eligible for registration in California; for 530-bed tuberculosis hospital situated in the foothills of Sierras between Sacramento and Reno on Highway 40; starting salary $300, increment to $330, differential of $10 for P.M. and night; 15 days paid vacation, 7 holidays, sick leave benefit, social security. Apply to Director of Nurses, Weimar Joint Sanatorium, Weimar, California.

NURSES—General duty; for 275-bed Chicago teaching hospital; salary $325 per month for P.M. duty; $315 per month for night duty, $300 per month for day duty, 40-hour week; Northwestern University affiliation with opportunity to take courses at half tuition; $10 a month salary increases on merit at 6 and 12 months and thereafter on special merit; 2 weeks vacation, 3 weeks after two years, 12 days sick leave, pension plan, social security; 3½ room apartments in building near Lake Michigan for $9.50 per week, two nurses to an apartment; $2.50 per week for one meal per day. Write or apply Personnel Department, Passavant Memorial Hospital, 303 East Superior, Chicago 11, Illinois.

SUPERINTENDENT OF NURSES—$5,512 to $7,078 annually; vacancy to occur within next few months; this is an ideal position in a 3,000-bed mental hospital with 500 employees in the nursing service; the hospital has a psychiatric affiliation with 40 student nurses; it is located in Traverse City, which has a population of 16,000 and is 250 miles northwest of Detroit in the heart of Michigan's resort area. For further information write to Michigan Civil Service Commission, Lansing 13, Michigan.

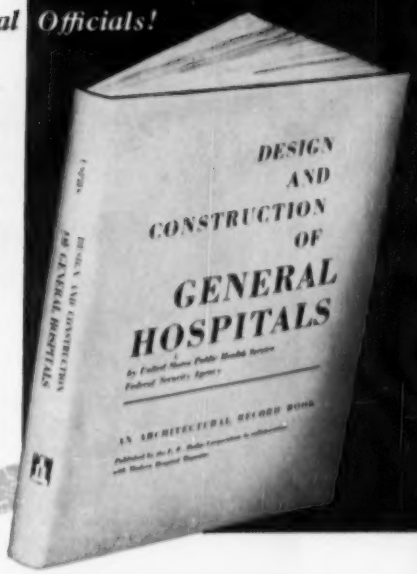
Enthusiastic Praise from Architects, Physicians, and Hospital Officials!

DESIGN and CONSTRUCTION OF GENERAL HOSPITALS

A collaborative publishing effort of...

- ARCHITECTURAL RECORD
- THE MODERN HOSPITAL

presenting the research findings of The United States Public Health Service



Recognized everywhere as the standard reference work on hospital planning, this book has won the highest praise from prominent figures in the field of architecture, medicine, and hospital administration. Based upon an extensive research study conducted by the Division of Hospital Facilities, U. S. Public Health Service, it analyzes and interprets the vast changes in hospital design brought about by rapid progress in medical science—notably in the new diagnostic, surgical, and therapeutic techniques which require equipment and facilities unknown a few years ago.

Published here, for the first time in any book, are the momentous research findings of the U. S. Public Health Service which are today serving as blueprints for truly modern general hospitals. Enlisted in this research project were the skills and experience of experts in the fields of architecture, engineering, medicine, hospital administration, nursing, and dietetics. As a result, this book provides to all who plan and build hospitals the same high quality of technical and consultative assistance that the Public Health Service renders in all of its programs to build the nation's health. The material, collected and organized by the editorial staffs of two outstanding professional journals—THE MODERN HOSPITAL and ARCHITECTURAL RECORD—makes by far the most authoritative volume on this all-important subject in print today.

214 pages • 8¾ x 11⅝ • Renderings, Drawings, Diagrams, $12.00

"unexcelled as guides to careful planning"

"Hospital authorities and their professional associates have, in fact, been waiting many years for such a book. The composite author groups have packed a great deal into 214 pages and have given us as much of perfection as we can expect in such a fluid area of planning as hospital construction...none of the principles or practices which are recorded here may be considered as final, but they are unexcelled as guides to careful planning..."

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"Recognition is due Marshall Shaffer and others for the excellence of the work, for its rational approach to hospital planning and construction, and the logical arrangement of subject matter, the completeness and comprehension of each step... where other works describe mainly the principles basic to hospital planning and construction, this one translates the principles into schematic drawings and illustrates how they can be carried out in hospitals as small as eight beds (nursing units or community clinics) and as large as 200 beds. Even more it provides detailed equipment lists and recent cost figures..."

MALCOLM T. MACEACHERN, M. D., *The Modern Hospital*

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"...The thoroughness with which this study has been carried out compels one...to classify it as a sort of dictionary or directory, veritably encyclopedic in make-up. One of its best features is its organization..."

ADDISON ERDMAN, A. I. A.
Journal of the American Institute of Architects

"reference and guide"

"Although the perfect hospital has never been constructed and probably never will be, the use of this volume as a reference and guide will prevent many of the errors that show up after completion..."

Journal of the American Medical Assn.

"practical handbook"

"It contains an invaluable collection of data and material on the subject of hospitals, and constitutes a practical handbook from which future planning may be based..."

LAURENCE P. JOHNSTON, A. I. A., *Hospitals*

PARTIAL CONTENTS

SECTIONS

I. SCHEMATIC PLANS OF GENERAL HOSPITALS
30 separate "pilot plans" for hospitals of various sizes, from 20-bed to 400-bed buildings

II. PLANNING THE STRUCTURE
- A. Site Selection
  - Accessibility
  - Public Utilities
  - Nuisance Problems
  - Orientation & Exposure
  - Costs
  - Dimensions
  - Topography
  - Landscaping
- B. The Building
  - General Considerations
  - Traffic: Exterior
  - Traffic: Interior
- C. Circulation Space
  - Corridors
  - Stairways
  - Elevators

III. ELEMENTS OF THE GENERAL HOSPITAL
- A. Main Lobby
  - Information & Switchboard
  - Admitting Office
  - Business Office
  - Administrator's Office
  - Medical Service Office
  - Director of Nurses' Office
  - Medical Record Room
  - Library & Conference Room
  - Staff Lounge & Locker Room
  - Gift Shop
  - Personal Toilets
- B. Nursing Facilities
  - Patient Areas
  - Two-bed Rooms
  - Four-bed Rooms
  - Isolation Units
  - Psychiatric Room
  - Treatment Room
  - Nurses' Station
  - Consultation Room
  - Utility Room
  - Floor Pantry
- C. Surgical Facilities
  - Operating Rooms
  - Sub-sterling Rooms
  - Scrub-up Facilities
  - Clean-up Room
  - Anesthesia Equipment Room
  - Cystoscopic Room
  - Fracture Room (Orthopedic)
  - Laboratory
  - Darkroom
  - Instrument Room
  - Surgical Supervisor's Office
  - Doctors' Locker Room
  - Nurses' Locker Room
  - Closets
  - Corridor
  - Central Supply Facilities
- D. Obstetrical Facilities
  - Delivery Rooms
  - Treatment Rooms
  - Supply Closet
  - Labor Rooms

IV. EQUIPMENT AND SUPPLY LISTS

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Please send me for 10 days FREE EXAMINATION a copy of "Design and Construction of General Hospitals." Within 10 days I will either send payment for $12.00, plus postage, or return the book without obligation.

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WHAT'S NEW FOR HOSPITALS

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 212. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Elastic Hosiery Now in Sheer Nylon

A 51 gauge, full-fashioned nylon elastic stocking is now available. Known as the R-1, the stocking is the result of years of research and testing. It is made of thin, light threads, yet it gives full support. The full-footed stocking exerts greatest pressure at the ankle, diminishing gradually up the leg in accordance with medical requirements.

Every thread in the R-1 is rubber covered with nylon. The seam of the stocking is pen-line thin, causing no discomfort or soreness. The heel is of non-rubber construction and when put on, it anchors the stocking in place to prevent pulling or cramping of the toes. Any type shoe may be worn with the stockings which are offered in a soft pastel shade. Small, medium and large sizes ensure proper fit for any patient since the long toe section is made of easily-stretched "Helanca" nylon yarn. **Bauer & Black, 309 W. Jackson Blvd., Chicago 6.**

For more details circle #315 on mailing card.

U.L. Approved Wax for Conductive Floors

Conductive floors in the surgery and other areas of the hospital can now be wax protected without reducing or losing conductivity. Huntington VC-2C and H-22 Conductive Waxes have been exhaustively tested by Underwriters Laboratories and have been listed as standard, according to the manufacturer. Conductive wax must be used on floors to retain the protective features where static electricity is a danger and conductive floors are installed.

VC-2C Conductive Wax is a clear wax for use on all types of conductive flooring. H-22 is a black wax designed for use on static-conductive linoleum, rubber and other black conductive floors. Both waxes may be polished to a high luster and produce a durable, water-resistant surface. Floors maintained with the new conductive waxes and washed with Spal Concentrate proved in special tests to retain safe electrical resistance after many days. **Huntington Laboratories, Inc., Huntington, Ind.**

For more details circle #316 on mailing card.

Hydrojette Humidifier Doubles as Aspirator

"Open-air" mist for the prevention and treatment of respiratory complications is provided with the new Hydrojette humidifier. The self-contained pressure-operated unit is combined with the Mobile Bedside Aspirator-Compressor

which may be used as a separate unit when desired.

The Hydrojette supplies therapeutic aerosol mist, with or without oxygen, with controlled suction. It can be used in an oxygen tent when the tent is indicated. Humidification is instantly available with the mobile, quiet Hydrojette unit. It occupies a minimum of bedside space and comes complete with the humidifying arm for direct application of the therapeutic aerosol mist. **Air-Shields, Inc., Hatboro, Pa.**

For more details circle #317 on mailing card.

Hair Remover for Surgical "Prepping"

Exare is the name given to a new hair removing cream. Designed specifically for preoperative removal of hair from the body, Exare removes hair in approximately ten minutes. It is a non-toxic preparation which will not cause skin irritation regardless of the length of time it is on the skin, according to the manufacturer. It leave the skin smooth and completely free from hair, including invisible fuzz. Exare is applied to the skin, allowed to remain for the necessary length of time, then washed off, leaving the skin clean and hair-free. It is available in six ounce jars. **S. M. Edison Chemical Co., 2710 S. Parkway, Chicago 16.**

For more details circle #318 on mailing card.

Speed and Convenience Feature TPR Board

The Bethesda TPR Board is a convenient, practical development for recording temperature, pulse and respiration. The compact unit consists of a board, shaped to rest against the nurses' body as she holds it in her left hand, on which is attached a data pad, electronic Therma Meter, full face watch with second hand, night light and pencil clip. All of the equipment required for taking and recording temperature, pulse and respiration is easily carried and conveniently held for maximum efficiency and accuracy in this routine nursing procedure.

Temperature is recorded on a dial on the Electronic Therma Meter, facilitating reading and assuring accuracy. The nurse's right hand is free to insert the Therma Meter probe, to take the pulse and to record the data. The night light illuminates just the board, permitting the nurse to attend to this routine duty at night without turning on room lights

and disturbing patients. The board is equally efficient for handling by a left handed nurse. **Medical Research Institute Inc., 909 Broadway, Cincinnati 2, Ohio.**

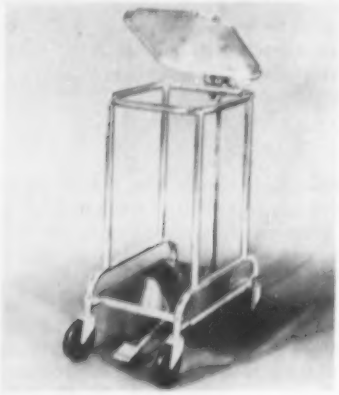
For more details circle #319 on mailing card.

(Continued on page 200)

WHAT'S NEW

Nursery Hamper Employs Regular Laundry Bag

A regular laundry bag is inserted into the new Debs Nursery Hamper for handling soiled linen and diapers in the nursery. The hinged stainless steel protective cover is raised or lowered by stepping on the readily available foot pedal. The hamper rolls easily and quietly on four Jarvis and Jarvis four inch casters. Rubber bumpers on the rear of the hinged cover protect walls.



The all-welded stainless steel No. F-72 Nursery Hamper is 16 by 26 inches in size, occupying minimum space. It is 34½ inches high. **Debs Hospital Supplies, Inc., 5990 Northwest Highway, Chicago 31.**

For more details circle #320 on mailing card.

Portable Unit for Oxygen Administration

The Pocketaire Oxygen Unit is a lightweight, compact case containing two standard "B" medical oxygen cylinders, a flow regulator with gauge and two disposable masks. It is designed for emergency use by those trained to give normal manual respiration as well as those inexperienced in oxygen administration. The overall weight of the unit is only 17 pounds. It can be easily transported and handled for quick delivery to the point of need in an emergency. It can be used in the hospital or in an ambulance. **The Cycle-Flo Company, Milford, Conn.**

For more details circle #321 on mailing card.

Flexible Vinyl Foam for Economical Upholstering

Comfort and economy are advantages offered in the use of the new Vicr-Foam flexible vinyl foam upholstery product. The versatile product is economical in first cost and easy to handle. It can be heat-sealed to any plastic, producing a smooth surface that will not wrinkle or slip out of place. It has high elasticity and resilience and is resistant to oxidizing or hardening and to oils, heat, moisture, aging, alkalies, acids and most chemicals. It is also resistant to fire as it is self-extinguishing. Vicr-Foam comes in continuous slabs which can be cut or die cast to any desired shape. **L. E. Carpenter & Co., Inc., Empire State Bldg., New York 1.**

For more details circle #322 on mailing card.

Cell Screening Device Speeds Cancer Detection

Screening of cell specimens for cancer detection has been a slow and painstaking job. Now a new device, called a "demi-automatic scanning microscope," is available to speed this work. It consists of a large inclined screen coupled with a microscope. Across the screen move magnified images of cell specimens which are on small glass slides under the microscope. The technique speeds the work approximately four times as compared to a technician looking through the microscope.

In operation, a specimen is placed under the Leitz Ortholux microscope. Underneath its stage is a motor which moves the slide and the cells slowly up and down and left and right. The image moves slowly on the screen at the right, magnified up to 2000 times and in full color. The technician watches for cellular size and the density of the chromatin material. A measuring device or movable marker is over the screen. When atypical cells are seen, motion is stopped and measurements are made. Even very small parts of the cell can now be measured. With a new automatic device, the technician pushes a release cable and a questionable area is marked directly on the glass slide. A Leica M-3 camera with built-in exposure meter is attached to the microscope for cell photography when desired. **E. Leitz, Inc., 468 Fourth Ave., New York 16.**

For more details circle #323 on mailing card.

(Continued on page 202)

Instrument Cabinet Has Movable Trays

Six movable trays are provided for the fumigation, disinfection and storage of urological instruments in the new Urological Instrument Cabinet. The top three trays are sectioned for instruments and are large enough for the storage of catheters. The bottom tray contains a compartment for a Salwen Formaldehyde Generator.

The 24 by 16 inch cabinet is ruggedly constructed of sheet steel on a steel frame, with baked enamel crackle finish. The top is of polished stainless steel for easy cleaning. Rubber casters and handles at each side of the cabinet make it easy to move. **American Cystoscope Makers, Inc., 1241 Lafayette Ave., New York 59.**

For more details circle #324 on mailing card.

Plastic Luminaire Provides Comfortable Lighting

Plastic sides and louvers are employed in the new Smithcraft Cleer Luminaire. The shallow, modern design gives comfortable lighting and is especially suited for installation in low ceilinged areas. It is wider than the conventional fixture and affords a high transmittance of glare-free lighting, unusually low in brightness. Spring clips hold the louver at a convenient level for re-lamping and cleaning.

The Smithcraft Cleer is available for two or four Rapid-Start Bi-Pin lamps in four and eight foot lengths, and for two or four T12 slimline lamps in eight foot lengths. **Smithcraft Lighting Div., Chelsea 50, Mass.**

For more details circle #325 on mailing card.

WHAT'S NEW

Texas-Ware Food Service in Attractive Patterns

The new decorated lines of Texas-Ware melamine dinnerware include

Checks, Angles, Autumn Leaves, Westwood, Tulips and Ovals. The new designs, in a variety of colors, provide an attractive, appetizing background for food. Texas-Ware is extremely durable and is light and easy to handle. Patterns are fadeproof and do not wear off with use as they are made an integral part of the dinnerware in the manufacturing process.

Texas-Ware Checks features a small checked border in green or red on bone white. The new continental coupe shape is used with the Angles pattern in pink, gold, torquoise and black in a modern design on bone white. Stylized, graceful leaves in the same four colors make up the Autumn Leaves pattern. Westwood reproduces the wood grain of natural walnut or birch as the overall pattern on the dinnerware. Modernized tulips in yellow, pink and green are used with matching border stripes for the tulip pattern, and a border of turquoise and brown ovals makes up another pattern in the new line. **Plastics Manufacturing Co., 825 Trunk Ave., Dallas 10, Texas.**

For more details circle #326 on mailing card.

Adjustable Height Bed Operates With Single Crank

The "Rite-Hite" Adjustable Height Hospital Bed, Model CT 4685/10, is operated with a single clutch handle on the back of the footboard. With clutch engaged, the hand-operated crank oper-

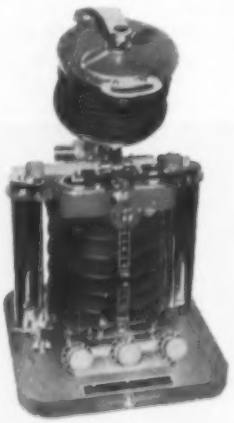
ates both head and foot ends simultaneously to attain hospital spring height or to lower the bed for greater patient comfort and safety. It can be disengaged to operate the foot end independently to obtain either Trendelenburg or Fowler positions.

The bed is equipped with Ultra-Variable, dual-crank spring and has semi-panel ends and square tubing legs. A similar bed, Model CT 4686/10, is available with bed end height adjustments accomplished by an electric motor. Both beds have three inch ball bearing casters for ease in moving. **Superior Sleeprite Corp., 759 S. Washtenaw Ave., Chicago 12.**

For more details circle #327 on mailing card.

Controlled Respiration Unit for Anesthetic Gases

The administration of anesthetic and therapeutic gases is improved with the new Stephenson Controlled Respiration Unit. The volume-controlled, pressure-limited breathing device is easily attached to any anesthetic gas machine. It has provision for any desired breathing pattern through independent controls for speed of inhalation, speed of exhalation



and duration of exhalation pause. Positive and negative pressure controls are also independently operated to provide any desired degree of ventilation.

The instrument can be converted to manual or to automatic operation at will and can be adjusted for administration of any volume of gas mixture to 1800 cc. Conductive components, rather than electric power, are used throughout to assure safety of operation. The unit is lightweight and portable, can be used with or without a stand, and is easy to clean. **Stephenson Corporation, Red Bank, N. J.**

For more details circle #328 on mailing card.

Portable Screen for Wide-Screen Projection

A new line of Radiant portable projection screens and frames is now available for 16 mm wide-screen projection. The new screen frame can be disassembled into sections and the fabric rolled up for convenient portability. The new screens are available in widths up to 32 feet. **Radiant Mfg. Corp., 2627 W. Roosevelt Rd., Chicago 8.**

For more details circle #329 on mailing card.

(Continued on page 204)

Wheelchair Seat Pad Provides Alternating Pressure

Alternating pressure pads for patients confined for long hours to wheelchairs or

other chairs is now available. The new Alternating Pressure Point Pad fits any chair and operates on the same principle as similar pads in bed size. A quiet electric motor drives an air pump which inflates and deflates alternate rows of air cells on a four-minute cycle, to prevent pressure spots and resulting sores. Pressure areas are gently massaged by the automatic action of the pad as it inflates and deflates. The new pad is designed especially for cases where shifting of body weight is difficult or impossible. **R. D. Grant Co., 805 Hippodrome Bldg., Cleveland 14, Ohio.**

For more details circle #330 on mailing card.

1956 Electric Dryers Speed Service

Speedier drying service is offered in the new 1956 line of National dryers. Stop-watch tests indicate that the new machines dry faster and more effectively. They are constructed for years of trouble-free service and maximum drying ability.

The new machines have porcelain-enamel finish and are available in color on special order. Exterior fittings are chrome plated and the sealed-in ball bearings are lubricated for the life of the dryer. Drying is started by pressing a button and stops automatically in the time required to dry hands thoroughly. Concealed mounting bolts and semi-concealed cover screws discourage theft. The drying nozzle pivots a full 360 de-

grees for easy drying of both face and hands. The dryer operates quietly and the manufacturer states it is approved by Underwriters Laboratories. **National Dryer Sales Corp., 616 W. Adams St., Chicago 6.**

For more details circle #331 on mailing card.

Why Hospitals Are Using Mechanical Card Filing For The Master Patient Index

More and more hospitals throughout the country are finding it pays to use Remington Rand Convé-Filer for the Master Patient Index because of big savings in reference time, clerical costs and filing efficiency. The operator remains comfortably seated. Just the touch of the toe on a foot pedal (or the finger on a push-button selector) and the tray containing any one of 200,000 cards is positioned electrically at convenient, efficient desk height. Convé-Filer is outstanding as the most efficient equipment yet developed for a large active card file. Exhaustive tests made by methods analysts show that savings to be obtained with Convé-Filer more than justify its original cost... savings of 30% on clerical cost alone. Get full particulars. Circle LBV160 on the coupon.

New, Compact Model 8 Camera – Ideal for Hospital Microfilming

The Remington Rand Film-a-record, Model 8 Microfilm Camera combines big machine performance with portability and economy. Requires no more space than a typewriter yet produces the finest, most accurate microfilm results. With microfilm, your hospital can quickly and economically modernize its record filing and retention system to conserve space, time and energy. Your case histories and hospital records on film conserve up to 94% of original-record filing space. Thousands of square feet of valuable hospital floor space can be immediately reclaimed for scientific and medical use.

Call Remington Rand for a free analysis of your hospital record-handling procedures.

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Get Free Manual on Proved Purchasing Procedures

The new manual, "Purchasing Procedures That Save Time and Money," can be your guide to more efficient buying. These new purchasing procedures tell you in an instant whether specifications are complete, whether hospital-wide needs have been anticipated, and how much an order can be increased or decreased.

You'll see methods that enable you to estimate deliveries and review experience with vendors. This free manual also features control of stock on hand and outstanding orders. Send for this buyers' guide. Circle X1202.

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H-14

WHAT'S NEW

Tomac Safety Sides Telescope Out of the Way

Tomac Telescopic Safety Sides fit all standard beds and telescope completely out of the way when not in use. Storage

problems are thus reduced, but the new sides are easily portable and can be quickly attached without tools when changed from one bed to another. When telescoped out of the way they do not interfere with foot room, containers or other objects under the bed and the telescoping sections slide easily and smoothly, staying securely in place when raised. A rubber wheel bumper is fitted to the upright section to prevent marring of walls when the sides are in position behind the bed.

The new sides are made of chrome plated steel and are ruggedly constructed for years of active service. They can be extended to a maximum of 86 inches in length and fold up to 7½ inches. **American Hospital Supply Corp., Evanston, Ill.**

For more details circle #332 on mailing card.

Specially Designed Patient Room Air Conditioner

Designed especially for hospital use, Philco Air Conditioner 284-M is offered on a rental plan with rates based on a moderate charge to the patient or a flat rate to the hospital. Thus room air conditioners can be installed without capital outlay by the hospital. The units are installed, serviced and maintained to hospital standards by the supplier.

The new air conditioner is designed to correct all four climatic problems in hospital rooms by a single automatic setting. In summer it cools and dehumidifies on hot days and nights and supplies needed warmth when the weather is chilly. In fall, winter and spring it supplies automatic supplemental heat in underheated rooms and automatic cooling in overheated rooms. It circulates and filters air continuously, keeps an even room temperature and exhausts odors. The unit is entirely inside the room. It is made to fit all types of windows. **U. S. Hospital Air Conditioning Engineers Inc., 1726 Eye St., N.W., Washington 6, D.C.**

For more details circle #333 on mailing card.

Colloidal Silica Is Soil Retardant

"Ludox" colloidal silica is a product of Du Pont research. It is a chemical used in formulation to treat rugs and carpets, fabrics, painted walls, wall paper and other surfaces to prevent dirt and soil from becoming embedded. "Ludox" does its work as a soil retardant by filling up the microscopically small pits and crevices, known as soil receptor sites, contained in all surfaces in varying degree. Once the tiny particles of silica fill these, the dirt must remain on the surface and is easily removed.

"Ludox" colloidal silica particles are so small that about 600 million would be required to cover the head of a pin. They are therefore small enough to enter and protect any site receptive to soil. The anti-soil solution is colorless, odorless, non-flammable and safe for use. It is available commercially through the floor covering industry and other applications will soon be announced. Patents are issued by Du Pont to manufacturers using the product. **E. I. du Pont de Nemours & Co., Wilmington, Del.**

For more details circle #334 on mailing card.

Improved Defibrillator Has High Output Voltage

The Levinthal Morris Clinical Defibrillator is available in an improved model. New design features include a higher output voltage, an accessory unit which provides continuously-variable output voltage and a redesigned housing case. Output-voltage settings of 185 and 220 volts have been added to facilitate defibrillation of enlarged hearts. A sturdy steel case finished in durable hammertone enamel in a light reddish-brown color now houses the improved model. It contains a convenient front opening storage

compartment beneath the apparatus.

Previously available series are retained as well as the automatically controlled pulse lengths and direct manual control. Isolation transformer, accessory explosion-proof footswitch and other safety devices are also retained. The Defibrillator is available separately or combined with the Levinthal Morris Clinical Pacemaker. **Levinthal Electronic Products, Inc., 2868 Fair Oaks Ave., Redwood City, Calif.**

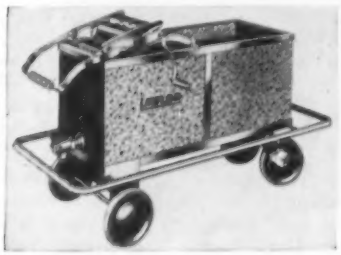
For more details circle #335 on mailing card.

WHAT'S NEW

Mopping Tank in Low Model

The new Lawlor Low-Boy is a two compartment mopping tank only 26 inches high in the 30 gallon model and 31 inches high in the 60 gallon model. The lower height gives added convenience and ease of operation. It also reduces the possibility of damage to fixtures in low ceiling areas.

Each tank of the Low-Boy has patented leakproof drain shut-off valve and is made of heavy galvanized steel, welded throughout. The chassis is angle and steel construction with solid steel, cadmium plated, ball-bearing, rubber tired wheels. The tank is available with or without rubber bumper rails. The hand-



pressure type wringer is adjustable for all mop weights and can be installed on either end of the tanks. **S. C. Lawlor & Co., 124 N. Aberdeen St., Chicago 7.**

For more details circle #336 on mailing card.

Streamlined Design in Visible Record Cabinet

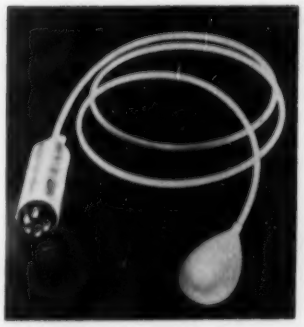
The Virginian Line cabinet for Acme Visible Records features modern, streamlined designing. A new light, warm color with stainless steel trim makes the new cabinet an attractive and harmonious addition to office equipment. Faster reference and posting are possible with the new functional design. Trays slide in and out smoothly and quietly between rubber guides, on nylon rollers. Wider slanted label holders on the cast tray fronts give improved indexing visibility.

Smoothly formed projections which act as invisible feet are features of the bottoms of all Virginia line cabinets. The projections fit into corresponding indentations in the top of the cabinets for secure stacking in tiers if desired. Desk type stands match the cabinets in color and design. Sliding work shelf with smooth vinyl plastic top and stainless steel edge and full width adjustable inside shelf give the stands wide usefulness for storage. **Acme Visible Records, Inc., Crozet, Va.**

For more details circle #337 on mailing card.

Safe Signaling From Oxygen Tents

A patient in an oxygen tent can safely signal with the new Sperti Faraday explosionproof locking button. Constructed



of non-conductive plastic, the device is a compact, contact-less, sturdy unit which can be operated by the slightest pressure of the patient's hand. **Sperti Faraday, Inc., Adrian, Mich.**

For more details circle #338 on mailing card.

Cork-Surfaced Trays Reduce Noise

New Kys-ite cork-surfaced trays cuts down noise and breakage. They are non-skid, reducing accidental spilling. The cork is molded into the plastic for permanence. Kys-ite trays may be washed in any manner as they are impervious to boiling. They are available in five sizes in red and brown. **Keyes Fibre Sales Corp., 420 Lexington Ave., New York 17.**

For more details circle #339 on mailing card.

Continued on page 206)

WHAT'S NEW

Record-Keeping Unit Saves Space

The new Remington Rand Roto-Kard is a drum record housing file handling

8 by 5 inch card records in one compact electrically or manually operated unit. The completely mobile Roto-Kard has a capacity of 6000 cards for a reference record or 4500 cards for a posting record. It is easily rolled to point of use and occupies only 3.6 square feet of floor area.

Removable self-contained desk-tray segments facilitate handling by several clerks during peak loads. A Slide-A-Deck feature permits shifting complete decks of cards between segments without misplacing or dropping. The Roto-Kard is built to standard desk height, eliminates excessive operator exertion and fatigue and contributes to efficiency of record-keeping. Individual record cards can be removed or inserted quickly without card damage. **Remington Rand Division, Sperry Rand Corporation, 315 Fourth Ave., New York 10.**

For more details circle #340 on mailing card.

Wool-Cotton Blankets Are Shrinkage Controlled

Shrinkage control has materially reduced shrinking in the No. 999 50 per cent wool, 50 per cent cotton hospital blanket. Given the Lanaset Resin shrink-treatment, the new 90 inch blanket showed shrinkage of only 3½ inches after exhaustive laundering tests administered by the America Institute of Laundering. This compares to shrinkage of approximately 10 per cent in untreated blankets of similar construction.

The specially treated blankets have been developed for use on the longer 80 inch mattresses. Even after repeated launderings the No. 999 shrinkage controlled blanket remains long enough to allow approximately six inches for tucking under. The blanket remains soft and comfortable, with the right weight and launderability for hospital use. **Chatham Manufacturing Co., 57 Worth St., New York 13.**

For more details circle #341 on mailing card.

Steraject Equipment in One-Piece Unit

Greater convenience in the use of the Steraject parenteral dosage forms is claimed for the new Steraject equipment. The new one-piece cartridge-sterile needle assembly is designed to ensure sterility by eliminating the handling of the needle. It is ready for use as made up and obviates the need for sterilizing the equipment before use. Steraject units are made up with a variety of antibiotics. **Pfizer Laboratories, Div. Chas. Pfizer & Co., Inc., 630 Flushing Ave., Brooklyn 6, N.Y.**

For more details circle #342 on mailing card.

Pressure Breathing Functions All Combined in One Unit

The Eliot Vent-El-Aire is a multi-purpose air pressure breathing unit which combines in a single unit all the main pressure breathing functions for the management of a variety of pulmonary disorders. It operates with room air supplied by integral motor compressors as a source of flows and pressures, without the need for oxygen. A simple connection, however, permits supplying oxygen whenever it is indicated for its therapeutic value. The unit is immediately ready for use by plugging into any electrical outlet.

The clearly defined control panel permits operation of the Vent-El-Aire with a minimum of instruction. The simple positioning of switches changes the functions of the unit in seconds. The Vent-El-Aire is effective in accomplishing the pressure breathing functions of cough, resuscitation, aerosol therapy, aspiration and wherever assistance in breathing or removal of mucous is indicated. **Eliot Medical Plastics, Inc., 429 Washington St., Lynn, Mass.**

For more details circle #343 on mailing card.

Bed Light Easily Controlled by Patient

Completely diffused up and down light with trigger start ballasts is provided with the new Lightolier hospital bed light. A pull switch within easy reach of the patient controls bed lighting and, if required, uplight may be controlled by a wall switch. Combining efficiency and comfort with trim, clean design, the bed light answers exacting lighting needs in the sick room. **Lightolier, Inc., Jersey City 5, N. J.**

For more details circle #344 on mailing card.

(Continued on page 208)

Disposable Hood for Oxygen Tents

A new, completely disposable hood is available for use with current as well as previous models of Ohio-Heidbrink oxygen tents. It is designed to save the time and effort involved in cleaning permanent type hoods and to eliminate danger of cross infection. The disposable hoods are made of lightweight clear plastic, have two convenient zipper openings, elastic hanger tabs and nylon draw cord. They supplement the line of permanent type hoods now available. **Ohio Chemical & Surgical Equipment Co., Madison 10, Wis.**

For more details circle #345 on mailing card.

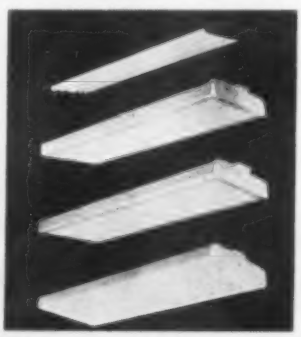
Oxygen Cannula of Lightweight Plastic

Featherweight plastic is used in the new Pharmaseal oxygen cannula. It is capable of delivering up to four liters of oxygen a minute and weighs only one-third of an ounce. Made of green tinted plastic, no headband is needed as it has reenforced ear pieces. The new Pharmaseal K-27 Nasal Oxygen Cannula is designed to permit the patient under therapy almost complete freedom of movement so that he can eat, drink and speak without difficulty. The unit is priced for expendability. **Pharmaseal Laboratories, 1015 Grandview Ave., Glendale 1, Calif.**

For more details circle #346 on mailing card.

Modern Shallow Design in "Basic Unit" Fixtures

The "Basic Unit" line of Slimline fixtures has been redesigned to give a modern shallow appearance. They match the Bipin Fluorescent Rapid Start units and the versatile series makes both Rapid Start and Slimline baskets interchangeable. Standard individual turret lampholders are utilized in all Slimline Basic Units: the Skyliner, Skylouver and Sky-Lume. Installation is simplified as is maintenance because of uniform lamp



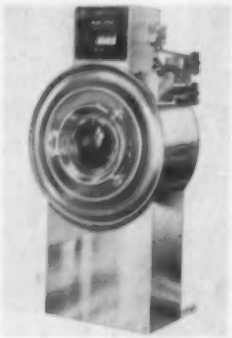
sizes, baskets with hinges from either side for lamp replacement, and easy removal of the basket for washing. **Electro Silv-A-King Corp., 1535 S. Paulina St., Chicago 8.**

For more details circle #347 on mailing card.

WHAT'S NEW

Automatic Laundrite Washer Has Large Capacity

A new model of the Laundrite automatic washer is now being offered in a 40 to 45 pound capacity. The new machine is similar in operation to the original Laundrite 25 pound capacity washer



brought out a little more than a year ago. It is designed for use where the volume, type of work and schedules indicate the need for the larger model.

Full range temperature control is provided through a selective thermostatic dial setting. Controls also provide automatic water level and cycle timing as well as dumping. Any change desired in the automatic operation is easily made by adjusting the dial. **Troy Laundry Machinery, Division of American Machine and Metals, Inc., East Moline, Ill.**

For more details circle #348 on mailing card.

Cooking Utensils Need No Scrubbing

A new technic has been developed for treating cooking utensils which is said to eliminate the need for soaking, scrubbing or scouring. Selinization is a method developed by S. A. Seline and his son, and has been laboratory tested for effectiveness. When factory applied to cooking utensils, greasing is not necessary as food does not stick to the treated materials. The process also protects utensils from discoloration, corrosion and pitting, according to the announcement. **Selinized Process Co., 1100 S. Saddle Creek Rd., Omaha 6, Neb.**

For more details circle #349 on mailing card.

Sterilizing Rack for Nails and Screws

Hip nails and screws are protected from damage during storage and autoclaving with the new DePuy advanced design Sterilizing Rack. The rack will handle several dozen nails and screws of various sizes and design and is quickly loaded. Nails and screws cannot fall from the rack while being carried with the convenient carrying handle. Rack No. 646 is constructed of stainless steel throughout. **DePuy Mfg. Co., Inc., Warsaw, Ind.**

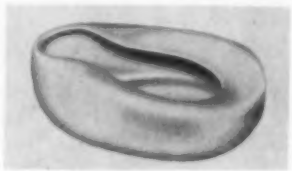
For more details circle #350 on mailing card.

WHAT'S NEW

Nylon Bed Pans Are Warm and Light

Bed pans molded of DuPont Zytel are now available in the line of Zylon hospital products. Patient comfort is increased since Zylon bed pans have the natural warmth of nylon. They are light in weight and flexible, making them easier to handle, and withstand autoclaving, boiling, detergents and conventional cold sterilizing agents. They are also resistant to hospital media, including chemicals that corrode and stain.

The new bed pans are molded in conventional design to facilitate the use of standard storage and sterilizing equipment. The sound absorbing quality of nylon reduces noise in handling. The new pans are available in adult size in gray and aqua. They are color matched to other Zylon hospital utensils, which include wash and emesis basins, forceps



jars, medicine cups, tumblers, juicers, soap dishes, sponge bowls and needle sterilizing trays. **Zylon Products Co., 27 Dryden Lane, Providence 4, R.I.**

For more details circle #351 on mailing card.

Flexalum "Twi-Nighter" Gives Shade and Ventilation

Annoying light leaks are eliminated with the Flexalum "Twi-Nighter" aluminum venetian blind, but ventilation is not cut off. The cord fittings in the new unit have been redesigned so that the slats fit snugly together when closed, keeping out all light.

"Twi-Nighter" blinds are offered in fifteen decorator colors, with marproof finish which does not chip, crack or peel. Flexalum tapes are of plastic which can be wiped clean and does not fade, fray, shrink or stretch. The colorful aluminum slats snap back into perfect shape, even if bent to a 90 degree angle. The cord controlling the position of the slat is nylon. **Hunter Douglas Corp., 150 Broadway, New York 7.**

For more details circle #352 on mailing card.

Cutting Board Is Sanitary and Odorless

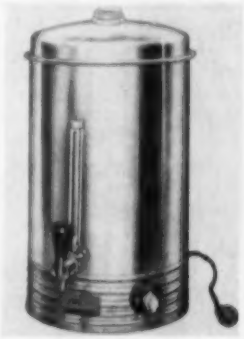
The Chem-Board is a chemically-impregnated, compressed cutting board made from solid hardwood of highest quality. It is resistant to slivering, cracking and warping and to the absorption of juices. Chem-Board is sanitary and odorless. It is easy to keep clean and is not harmed by severe sterilization. **Chem-Wood Products, Inc., 1115 W. Florida St., Seattle 4, Wash.**

For more details circle #353 on mailing card.

(Continued on page 210)

Portable Coffee Urn Is Complete Unit

The all new Portable Electric Coffee Saver Urn heats its own water, brews the



coffee and keeps it hot for serving. It is operated by plugging into any outlet and makes three gallons of full-flavored coffee. The stainless steel unit features a permanent "coffee-saver" filter, three heat control switch, visual gauge glass and heavy duty automatic closing serving faucet designed to prevent drip.

Full flavored coffee is assured as the water rises to the filter only when the correct brewing temperature is reached. The strength of the coffee is controlled by the brewing time. **Cecilware-Commodore Products Corp., 199 Lafayette St., New York 12.**

For more details circle #354 on mailing card.

WHAT'S NEW

Combination Centrifuge Has Hematocrit Head

A special Micro-Hematocrit head, giving up to 11,000 r.p.m. on alternating

current, is a combining part of the new Model L-708 Combination Clinical Centrifuge. When the Micro-Hematocrit head is removed and replaced with a regular four place slotted trunnion type head or up to 24 page angle type head, the new L-708 is converted to a regular clinical centrifuge. The Micro-Hematocrit head has 24 slots, each numbered for careful identity of samples. A guard plate screws down over the hematocrit head to hold tubes safely in place while running.

The new centrifuge is of all welded steel construction with gray metallic hammertone finish. It starts fast, is vibrationless in operation, and has variable speeds controlled by a vitreous enamel rheostat. The new lightweight model is readily portable. **Phillips-Drucker, 2245 S. Vandeventer Ave., St. Louis 10, Mo.**

For more details circle #355 on mailing card.

Adding-Bookkeeping Machine Uses Standardized NCR Forms

All of the basic bookkeeping tasks in a small or medium-sized business office can be handled on the new double duty adding-bookkeeping machine introduced by National Cash Register Company. Standardized NCR bookkeeping forms have been designed for use with the machine, providing a complete "package" at relatively low cost. Rapid conversion from one job to another is accomplished by interchangeable control bars. A switch at the left instantly changes it from bookkeeping into a flexible-keyboard adding machine.

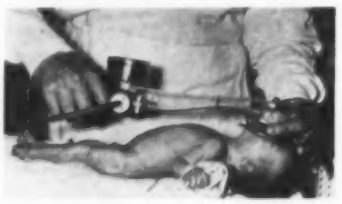
Many features of higher-priced models have been incorporated into the new machine. The forms to go with the machine are made of NCR (No Carbon Required) paper, which is chemically coated to reproduce sharp, clear impressions on multiple forms without the use of carbon paper. **The National Cash Register Co., Dayton 9, Ohio.**

For more details circle #356 on mailing card.

Infant Resuscitator Is Hand-Operated

The GBL Infant Hand Resuscitator requires no electricity or other power and affords a means of providing accurately controlled intermittent positive pressure breathing to expand safely the atelectatic lung of the newborn. The instrument is entirely under the control of the administering physician.

The unit weighs less than three pounds, is compact in size and is assembled and ready for instant emergency use as packed in its carrying case. Four sizes of masks and four tracheal catheter adapters are included with each unit. An oxygen concentration chart is located on the cover of the case for convenience. The instrument was developed by a team of medical and engineering specialists under the leadership of Goddard, Clark and Bennett at the Lovelace Foundation



for Medical Education and Research. **V. Ray Bennett & Associates, Inc., 320 S. Robertson Blvd., Los Angeles 48, Calif.**

For more details circle #357 on mailing card.

WHAT'S NEW

Pharmaceuticals

Placidyl

Placidyl is a mild, nonbarbiturate hypnotic offering a gentle source of sleep for patients troubled by ordinary nervous insomnia. It provides mild hypnosis without initial excitation or hangover, and takes effect within 15 to 30 minutes. Side actions are negligible in incidence and the drug is not contraindicated in liver or kidney disease, according to the report. Placidyl is supplied in 500 mg. capsules in bottles of 100. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #358 on mailing card.

Pen-Vee, Oral

Pen-Vee, Oral is the name given to a new type of oral penicillin which is highly resistant to destruction by the acids of the stomach and readily absorbed by the bloodstream. Penicillin V is the result of years of investigation and research. It differs essentially from earlier forms of penicillin due to its altered physio-chemical properties. Most important is its stability in acid, but high rate of absorption. Pen-Vee, Oral is reported as being found most effective in the treatment of infections susceptible to penicillin therapy. **Wyeth, Inc., 1401 Walnut St., Philadelphia 2, Pa.**

For more details circle #359 on mailing card.

Vitamin Products

Two new vitamin products have been added to the Mead Johnson line of nutritional and pharmaceutical specialities. Deca-Vi-Sol is a new drop dosage dietary supplement containing ten biologically significant vitamins. It is indicated for use by infants and children as protection against vitamin deficiencies in the diet. It is supplied in 15, 30 and 50 cc dropper bottles. Natalins-PF, the second new vitamin product, is a phosphorus-free vitamin-mineral capsule for use in pregnancy and lactation. It contains a balanced range of nutrients and is supplied in bottles of 100 capsules. **Mead Johnson & Co., Evansville 21, Ind.**

For more details circle #360 on mailing card.

Becejex

Becejex is a new injectible solution for the treatment of vitamin B and C deficiency. It is administered by intramuscular or intravenous injection in a wide variety of conditions where a rapid build-up of vitamin reserves is indicated. It may also be added to such intravenous infusions as glucose or saline. Becejex is also beneficial in cases where the diet is known to be deficient in vitamins B and C. It is supplied as a ready-to-use, stable solution. **Winthrop Laboratories, Inc., 1450 Broadway, New York 18.**

For more details circle #361 on mailing card.

Sandril

Sandril, Lilly reserpine, is available in two new forms—an ampoul and a 5 mg. tablet. Both are indicated in the treatment of psychiatric conditions such as schizophrenia, paranoia and manic states. The ampoul form is indicated in the treatment of conditions in which the patient cannot or will not swallow oral doses or for use in regimens combining both intramuscular and oral medication. The new 5 mg. tablet form is designed for use where large doses of reserpine are required. **Eli Lilly and Co., Indianapolis 6, Ind.**

For more details circle #362 on mailing card.

Cordex

Cordex is a new drug combining prednisolone, the potent "cousin" of hydrocortisone, with acetyl-salicylic acid, and providing both anti-inflammatory and analgesic action. Tests indicate that Cordex is more effective than either drug alone in the amounts employed and that an added anti-inflammatory effect is produced by the combination. The new drug is designed for patients with mild to moderate conditions of rheumatoid arthritis, osteoarthritis, gouty arthritis, bursitis, myositis, tenosynovitis, fibrositis and neuritis. **The Upjohn Co., Kalamazoo, Mich.**

For more details circle #363 on mailing card.

(Continued on page 212)

PRODUCT INFORMATION

Index to "What's New"

Pages 199-212

Key

213 51 Gauge Elastic Hosiery
Bauer & Black

214 Conductive Waxes
Huntington Laboratories

217 Hydrolate Humidifier
Air-Shields, Inc.

218 Enure Hair Removing Cream
S. M. Edison Chemical Co.

219 Bethesda TPN Board
Medical Research Institute Inc.

220 Nursery Hamper
Debe Hospital Supplies, Inc.

221 Pocketchic Oxygen Unit
The Cycle-Flo Co.

222 Upholstery Material
L. E. Carpenter & Co., Inc.

223 Call Screening Device
E. Leitz, Inc.

224 Urological Instrument Cabinet
American Cystoscope Makers Inc.

225 Clear Luminaire
Smithcraft Lighting Div.

226 Texon-Ware
Plastics Mfg. Co.

227 Adjustable Height Bed
Superior Sleepsite Corp.

228 Controlled Respiration Unit
Stephenson Corp.

229 Portable Screen
Radiant Mfg. Co.

230 APF Seat Pad
R. D. Grant Co.

231 1958 Line of Dryers
National Dryer Sales Corp.

232 Telescopic Safety Sides
American Hospital Supply Corp.

235 Air Conditioner
U. S. Hospital Air Conditioning Engineers Inc.

314 "Ludox" for Soil Resistance
E. I. Du Pont de Nemours & Co.

235 Improved Defibrillator
Lavinthal Electronic Products, Inc.

Key

236 Low-Boy Mopping Tank
S. C. Lawlor & Co.

237 Visible Record Cabinet
Acme Visible Records, Inc.

238 Explosionproof Signal Button
Sperti Faraday, Inc.

239 Cork-Surfaced Trays
Keyes Fibre Sales Corp.

240 Roto-Kard
Remington Rand

241 Shrinkage Controlled Blanket
Chatham Mfg. Co.

242 Steraject 1-piece Assembly
Pfizer Laboratories Div.

243 Vent-El-Aire
Elkor Medical Plastics Inc.

244 Louvron Fixtures
Lightolier, Inc.

245 Disposable Hood
Ohio Chemical & Surgical Equipment Co.

246 Oxygen Cannula
Pharmaseal Laboratories

247 Redesigned "Basic Unit"
Electro Silv-A-Ette Corp.

248 40 Pound Washer
Troy Laundry Machinery Div.

249 Sublimation
Sublimed Process Co.

250 Sterilizing Rack
DePuy Mfg. Co., Inc.

251 Nylon Bed Pans
Zylon Products Co., Inc.

252 Flexalum "Twi-Nighter"
Hunter Douglas Corp.

253 Chem-Board for Cutting
Chem-Wood Products, Inc.

254 Portable Coffee Saver Urn
Cecilware-Commodore Products Corp.

255 Combination Centrifuge
Phillips-Drucker

256 Adding-Bookkeeping Machine
National Cash Register Co.

Key

257 Infant Head Resuscitator
V. Ray Bennett & Associates

258 Placidyl
Abbott Laboratories

259 Pen-Vee, Oral
Wyeth, Inc.

260 Disco-Vi-Sol, Nutalins-PF
Mead Johnson & Co.

261 Beesix
Winthrop Laboratories Inc.

262 Sendril
Eli Lilly and Co.

263 Cordex
The Upjohn Co.

264 Pharmacy Equipment Catalog
Grand Rapids Sectional Equipment Co.

265 Folder
Porto-Lift Mfg. Co.

266 "Professional Cleansing of Glass"
Finger Lakes Chemical Co.

267 "Make Your Gloves Last"
The Macmillan Rubber Co.

268 Bulletin No. 135
Swivelier Co., Inc.

269 Folder on Cleaner
Castle Products, Inc.

270 Bulletin PSG-2
Henry Vogt Machine Co.

271 Abstract of Changes and Additions
Mallinckrodt Chemical Works

272 "Flying Saucers"
Economics Laboratory, Inc.

273 Catalog
National Cylinder Gas Co.

274 Thorazine Reference Manual
Smith, Kline & French Laboratories

275 "The Care of Concrete Floors"
National Sanitary Supply Co.

276 Catalog H-87
Kohler Co.

277 Book
Physicians' Record Co.

Index to Products Advertised

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—32nd Edition

Key	Page
278 Abbott Laboratories	26, 27
279 Abbott Laboratories	111
280 Adams & Westlake Company (HPF)	46
281 Advance Floor Machine Company (HPF)	207
282 Air Maze, Inc.	168
283 Air-Shields, Inc. (HPF)	51
284 Air-Shields, Inc. (HPF)	139
285 Alco Company, A. S. (HPF)	201
286 American City Bureau	180
287 American Hospital Supply Corp. (HPF)	42, 43
288 American Laundry Machinery (HPF)	
289 American Machine & Metals,	
290 American Sterilizer Company	
291 American Sterilizer Company	
292 Angelica Uniform Company	

INDEX CONTINUED ON FOLLOWING PAGE

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January, 1956

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WHAT'S NEW

315	316	317	318	319	320
321	322	323	324	325	326
327	328	329	330	331	332
333	334	335	336	337	338
339	340	341	342	343	344
345	346	347	348	349	350
351	352	353	354	355	356
357	358	359	360	361	362
363	364	365	366	367	368
369	370	371	372	373	374
375	376	377			

ADVERTISEMENTS

378	379	380	381	382	383	384	385	386	387	388	389	390	391	
392	393	394	395	396	397	398	399	400	401	402	403	404	405	
406	407	408	409	410	411	412	413	414	415	416	417	418	419	
420	421	422	423	424	425	426	427	428	429	430	431	432	433	
434	435	436	437	438	439	440	441	442	443	444	445	446	447	
448	449	450	451	452	453	454	455	456	457	458	459	460	461	
462	463	464	465	466	467	468	469	470	471	472	473	474	475	
476	477	478	479	480	481	482	483	484	485	486	487	488	489	
490	491	492	493	494	495	496	497	498	499	500	501	502	503	
504	505	506	507	508	509	510	511	512	513	514	515	516	517	
518	519	520	521	522	523	524	525	526	527	528	529			

NAME _____ TITLE _____

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WHAT'S NEW

315	316	317	318	319	320
321	322	323	324	325	326
327	328	329	330	331	332
333	334	335	336	337	338
339	340	341	342	343	344
345	346	347	348	349	350
351	352	353	354	355	356
357	358	359	360	361	362
363	364	365	366	367	368
369	370	371	372	373	374
375	376	377			

ADVERTISEMENTS

378	379	380	381	382	383	384	385	386	387	388	389	390	391	
392	393	394	395	396	397	398	399	400	401	402	403	404	405	
406	407	408	409	410	411	412	413	414	415	416	417	418	419	
420	421	422	423	424	425	426	427	428	429	430	431	432	433	
434	435	436	437	438	439	440	441	442	443	444	445	446	447	
448	449	450	451	452	453	454	455	456	457	458	459	460	461	
462	463	464	465	466	467	468	469	470	471	472	473	474	475	
476	477	478	479	480	481	482	483	484	485	486	487	488	489	
490	491	492	493	494	495	496	497	498	499	500	501	502	503	
504	505	506	507	508	509	510	511	512	513	514	515	516	517	
518	519	520	521	522	523	524	525	526	527	528	529			

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Key

ex to Products Advertised—*Continued*

WHAT'S NEW

Product Literature

• Grand Rapids **Sectional Equipment for the Hospital Pharmacy** is described and illustrated in a new 12 page catalog released by Grand Rapids Sectional Equipment Co., 11 Fuller Ave., S.E., Grand Rapids 6, Mich. The "building block flexibility" of the equipment for hospital pharmacy needs is discussed as is the fine furniture construction employed, the low cost installation and the efficiency of the equipment. One section of the catalog illustrates the adaptability of the sectional equipment for any pharmacy needs and for any available space. Also included is information on multiple sections, cupboard units, sinks and cradle cabinets.
For more details circle #364 on mailing card.

• **How the Porto-Lift offers new freedom of movement for the invalid** is discussed in a new folder released by Porto-Lift Mfg. Co., 1412 N. Larch St., Lansing 5, Mich. Photographs and descriptive text tell how the Porto-Lift is used to lift, transfer and rehabilitate bed patients. It is easy to operate, safe and gentle in its handling of incapacitated patients, and can be used to lift patients in and out of bathtubs as well as beds, wheelchairs, cars and chairs.
For more details circle #365 on mailing card.

• **"Professional Cleansing of Biological Glassware"** is the title of a new booklet prepared by Finger Lakes Chemical Co., Etna, N.Y. Effective cleaning methods for hand and machine washing of utensils used in biological and serological technics are described. Information is also included on Bio-Lab and Liquid Bio-Lab for hand washing and Bio-Machine and Liquid Bio-Machine for machine washing of glassware.
For more details circle #366 on mailing card.

• **"Suggestions to Make Your Gloves Last Longer"** are given in a folder published by The Massillon Rubber Company, Massillon, Ohio. Illustrated with amusing line drawings, the text covers such subjects as washing, storing, powdering, sorting, testing, sterilizing and similar details of glove care.
For more details circle #367 on mailing card.

• Data on the line of **New Swivelier Hospital-Lites** is given in **Bulletin No. 135** released by Swivelier Company, Inc., 43 34th St., Brooklyn 32, N. Y. Exclusive features of these universally adjustable lights with the coolite shade are shown in text and illustration.
For more details circle #368 on mailing card.

• Action, use and advantages of **Oakite General Cleaner** are discussed in a folder issued by Oakite Products, Inc., 128D Rector St., New York 6. Many cleaning jobs can be done by hand with the new cleaner which is described as offering the advantages of controlled action, safety, low cost, fast cleaning and good rinsing.
For more details circle #369 on mailing card.

• **"Package Unit Steam Generators"** are the subject of **Bulletin PSG-2** issued by Henry Vogt Machine Co., 10th & Ormsby Sts., Louisville 10, Ky. How these safe, portable water tube boilers function, details of construction and design, and capacities, dimensions and weights are some of the details covered in the eight page booklet.
For more details circle #370 on mailing card.

• Designed to serve as a convenient reference for pharmacists and others concerned with drugs, Mallinckrodt Chemical Works, 2nd & Mallinckrodt Sts., St. Louis 7, Mo., has published an **Abstract of Changes and Additions in the U.S.P. XV and N.F.X.** A complete list of products admitted to the U.S.P. XV and N.F.X. is contained in the booklet which also designates significant changes in products, titles, tests and specifications.
For more details circle #371 on mailing card.

• **"Flying Saucers"** is the intriguing title given to the booklet on dish handling prepared by Economics Laboratory, Inc., 250 Park Ave., New York 17. The booklet represents the results of a three year study as well as field experience in the breakage problem. It is a guide and reference to information presented in two new films developed by the company, "Flying Saucers" and "Spotlight Breakage." Helpful information on how to reduce breakage of dishes and glassware is presented in the booklet.
For more details circle #372 on mailing card.

• **Hospital piping equipment** is the subject of a new 12 page catalog issued by the Medical Division, National Cylinder Gas Co., 840 N. Michigan Ave., Chicago 11. All important equipment in the NCG line, old and new, is described and illustrated in the booklet. Also covered is specific information on NCG planning services and a page of photographs of award-winning hospitals served by NCG piping equipment. Also available is a handy slide calculator which gives the flow capacities of various pipe sizes, computed to various pipe lengths.
For more details circle #373 on mailing card.

• The **Thorazine Reference Manual, First Edition,** November 1955, is available from Smith, Kline & French Laboratories, 1530 Spring Garden St., Philadelphia 1, Pa. The 72 page booklet contains comprehensive information on all of the established clinical uses of Thorazine.
For more details circle #374 on mailing card.

• The National Sanitary Supply Association, Inc., 139 N. Clark St., Chicago 2, has issued a new booklet on **"The Care and Maintenance of Concrete Floors."** The 12 page booklet describes the basic concrete floor and illustrates some of the more common faults due generally to improper construction or improper maintenance. Cleaning, finishing and daily maintenance tips for concrete flooring are discussed.
For more details circle #375 on mailing card.

• **Kohler Plumbing Fixtures for hospitals, medical and dental clinics, sanitariums and allied uses** are described and illustrated in **Catalog H-57.** The 48 page catalog is printed in two colors and gives detailed information on the completely revised Kohler hospital line with pictures of the hundreds of standard and specialty items available to medical institutions. Kohler electric plants and their value to hospitals as standby protection are discussed in a three-page section.
For more details circle #376 on mailing card.

Book Announcements

Huffman, "Manual for Medical Record Librarians," 4th ed., 636 pp., $9.75. **Physicians' Record Co., 161 W. Harrison St., Chicago 5.**
For more details circle #377 on mailing card.

Suppliers' News

American Radiator & Standard Sanitary Corp., 40 W. 40th St., New York 18, manufacturer of plumbing and heating equipment, announces the dissolution of its wholly-owned subsidiary, **Kewanee-Ross Corporation, Kewanee, Ill.,** and the formation of two new American-Standard operating divisions to continue Kewanee-Ross operations. The two new divisions will be the **Kewanee Boiler Division,** which will manufacture Kewanee boilers, and the **Ross Heat Exchanger division,** which will produce Ross heat exchangers, surface condensers and allied products.

The Colson Corporation, Elyria, Ohio, manufacturer of casters, materials handling equipment and wheeled goods, announces the opening of a new factory, designed with removable walls on two sides. The new plant is the first of six identical adjoining plants planned by the company. When adjoining sections are constructed the side walls can be removed to afford open bays, and parts of the removed walls will be used as the outside walls of the new structures.

Day-Brite Lighting, Inc., 5411 Bulwer Ave., St. Louis 7, Mo., engineer, designer and manufacturer of lighting equipment, announces the opening of its Western Division plant, offices and display room on **Martin Ave., Santa Clara, Calif.**

Huntington Chair Corporation, Box 2111, Huntington, W. Va., manufacturer of quality furniture, announces the opening of a new showroom at **96 Northeast 40th St., Miami, Florida.** The large new structure is laid out for effective display of the more than 170 patterns in the Huntington furniture line, including case goods, seating and sleeping room furniture, tables and desks. A feature of the permanent exhibit is a display of prebuilt units, built to architects' specifications and designed especially for nursing school and other dormitories.

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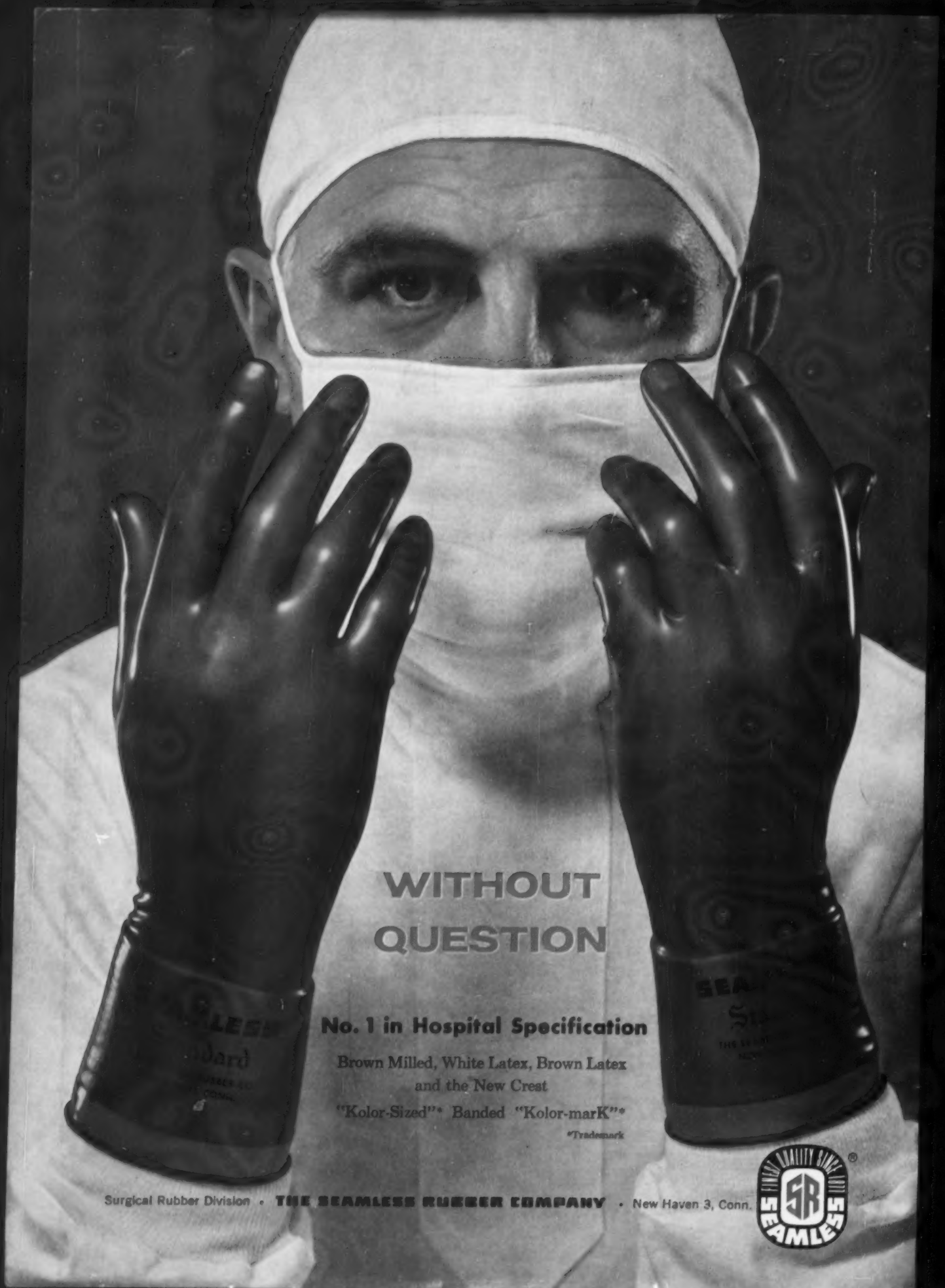
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